

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
417
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 6yr. 3mo. 16days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		15-22-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 207 E. Indian Spring Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Angelina Middle AGRIESTI Last AGRIESTI		4. DATE OF DEATH Month January Day 19 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-1884
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S. - Naturalized	
13. FATHER'S NAME Samuel DelVecchio		14. MOTHER'S MAIDEN NAME Marie Stango	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-15 1961 , to 1-19 1961 , that (I) (we) last saw the deceased alive on Jan. 18 1961 , and that death occurred at 7 AM, from the causes and on the date stated above.			
22a. SIGNATURE Ilse Kamm, M.D.		22b. DATE SIGNED 1-19-61	
22c. PHYSICIAN'S NAME (Type) Ilse Kamm, M. D.		22d. ADDRESS Springfield State Hospital - Sykesville	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-23-61		23b. DATE THEREOF ST Mary's Cem	
23c. NAME OF CEMETERY OR CREMATORY Washington D.C.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. Tim Lee & Sons		25a. REC'D BY REGISTRAR 300 H St N.E.	
25b. REGISTRAR'S SIGNATURE Arthur S. Travis		DATE JAN 23 '61	

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

CERTIFICATE OF DEATH

Reg. Dist. No.

00416

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u>	
c. LENGTH OF STAY IN 1b <u>MONTHS</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JACOB</u> First <u>FURRY</u> Middle <u>ALTWATER</u> Last <u>SR</u>		4. DATE OF DEATH <u>JAN</u> Month <u>7</u> Day <u>1961</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3-1883</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM ALTWATER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE BUCHET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>LYDIA S. ALTWATER</u>		Address <u>MIDDLEBURG MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>422-2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Myocarditis, Pulmonary ascess</u> DUE TO (c) <u>1 mo</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-4</u> , 19 <u>60</u> , to <u>1-7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1-5-</u> 19 <u>61</u> , and that death occurred at <u>4:15 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Legg</u>		ADDRESS (Street, city or town, state) <u>Union Bridge</u> DATE SIGNED <u>1-8-61</u>	
PHYSICIAN'S NAME (Type) <u>T. H. LEGG</u>		<u>UNION BRIDGE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 10-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BRETHREN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ROCKY RIDGE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hartley</u>		ADDRESS <u>UNION BRIDGE MD</u>	
24a. REC'D BY REGISTRAR <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. S. Kline</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 5/58

CERTIFICATE OF DEATH

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515
419
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
60417

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>18yrs 4m 24d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3001.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield St. Hospital</u>		d. STREET ADDRESS <u>601 South Street</u>	
3. NAME OF DECEASED (Type or print) <u>Victor Gerard Andrew</u>		4. DATE OF DEATH <u>June 22 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 - 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR <u>70</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>F. E. Andrew</u>		14. MOTHER'S MAIDEN NAME <u>Joanna Gurnea</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>-</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.0</u> DUE TO <u>Bilateral bronchial pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Cardiovascular disease</u> DUE TO <u>Congestive heart failure due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unstable angina pectoris</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1955</u> to <u>Jan 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 21, 1961</u> , and that death occurred at <u>1:05 P.M.</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>Myron W. Winkowski</u>		22b. DATE SIGNED <u>Jan 21, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Myron Winkowski</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Tichauer & Sons</u>		25a. REC'D BY REGISTRAR <u>Jan 23 '61</u>	
ADDRESS <u>Belts 17, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

515

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OR

CL. 1911

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Carroll					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville					b. COUNTY Baltimore Co.						
c. LENGTH OF STAY IN 1b 3 weeks					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 3514 White Ave.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Beulah Sophie Askew			4. DATE OF DEATH Month Day Year January 27 1961								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 24, 1881		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Seebo					14. MOTHER'S MAIDEN NAME Minna Heiliger						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. -			17. INFORMANT Springfield Hospital Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarct due to pulmonary embolism DUE TO 904.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of left femur DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumatic heart disease with mitral stenosis; years: CBS assoc. cer. art.										INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Don't know								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 12-25 19 60			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Don't know			20f. (City or town) (County) (State) Baltimore, Balt. Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <i>James T. Marsh</i> EXAMINER'S NAME (Type) James T. Marsh, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1-27-61					DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Jan. 30, 1961			22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.			22d. LOCATION (City, town, or country) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR William Cook-Blight, Inc.						ADDRESS 6009 Harford Road			24a. REC'D BY REGISTRAR DATE JAN 31 '61		
									24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

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FOR STATE
OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06419

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. Route # 1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>R.F.D. Route # 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Eliza Bailey</u> First Middle Last 4. DATE OF DEATH <u>Jan 16 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-20-1868</u> AGE (In years last birthday) <u>93</u> yrs. 9. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Harford County</u> 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James B. Wakeland</u> 14. MOTHER'S MAIDEN NAME <u>Susan ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mr. James R. Bailey</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Softening</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unknown</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>about June 1957</u> to <u>Jan 16 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 9 1961</u> , and that death occurred on <u>Jan 16 1961</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>DRE, Reese Wilkens</u> 22c. PHYSICIAN'S NAME (Type) <u>DRE, Reese Wilkens</u>		22b. DATE SIGNED <u>Jan 16 1961</u> 22d. ADDRESS <u>15 Kemper Ave, Westminster Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J Pickens & Sons</u> ADDRESS <u>Baltimore 17 Md</u>		25a. REC'D BY REGISTRAR <u>JAN 17 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M II/59

422

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66420

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 mos. 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
3. NAME OF DECEASED (Type or print) First James Middle Warner Last Bandel		4. DATE OF DEATH Month January Day 17 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office worker		10b. KIND OF BUSINESS OR INDUSTRY B.&O. Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. Franklin Bandel		14. MOTHER'S MAIDEN NAME W. Alice Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Charles C. Simpson		Address 107 Spa View Avenue Springfield Hospital Records Annapolis	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 30, 1960 to January 17, 1961 that (I) (we) last saw the deceased alive on January 16, 1961 and that death occurred at 3 A.M. from the causes and on the date stated above			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 1/17/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Lipner & Sons		25a. REC'D BY REGISTRAR DATE JAN 18 '61	
ADDRESS H & Penn Ave 17		25b. REGISTRAR'S SIGNATURE Carlton S. Houser	



CERTIFICATE OF DEATH

Reg. Dist. No.

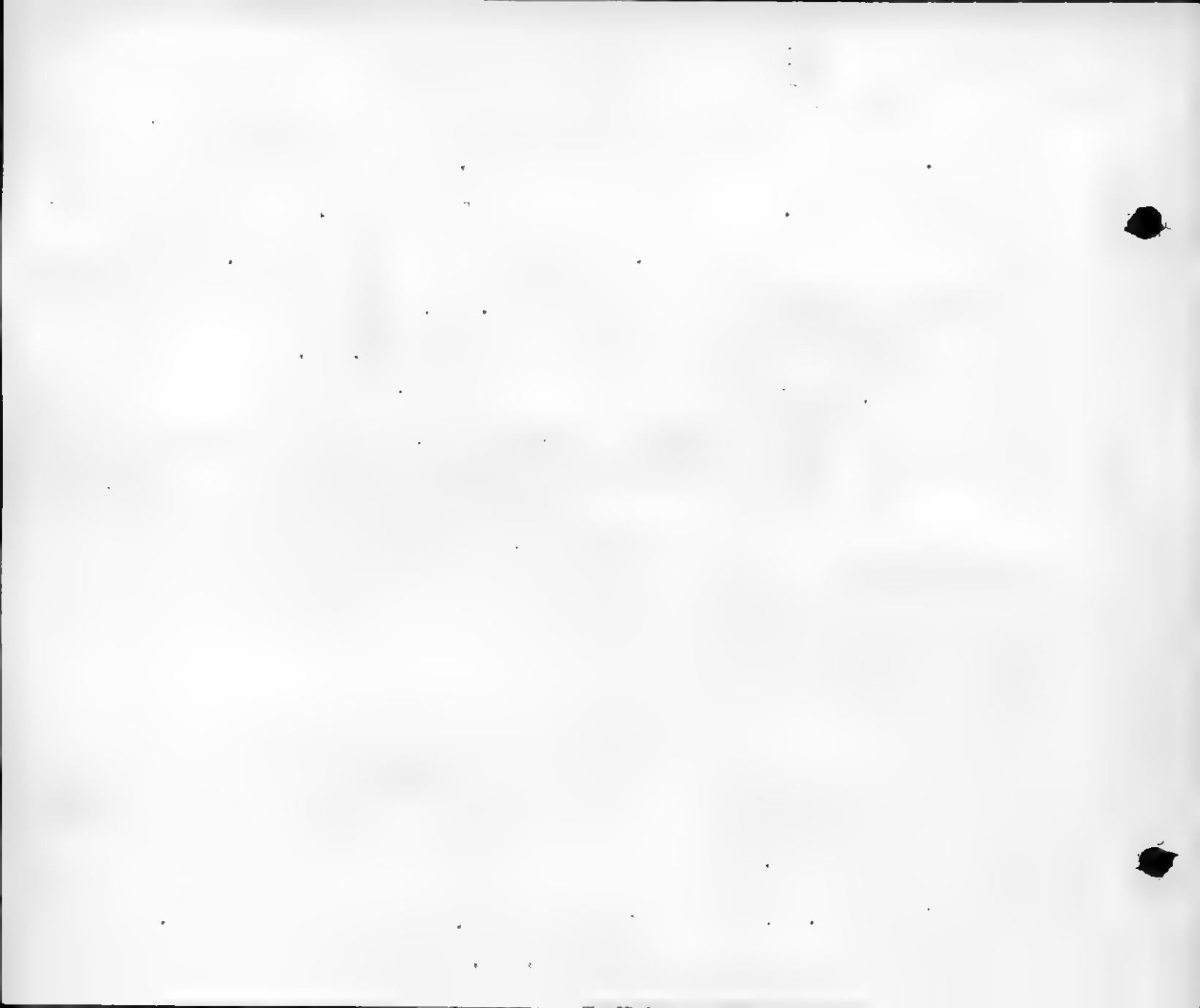
00421

423

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 307 Park Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Melvin Middle W. Last Beall		4. DATE OF DEATH Month Jan. Day 18 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1879
9. AGE (In years lost birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Clarksburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Beall		14. MOTHER'S MAIDEN NAME Summerville King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Eva Beall		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 18, 1947 to January 18, 1961 , that I last saw the deceased alive on January 18, 1961 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 1/21/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 22, 1961	
22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mohamath		24a. REC'D BY REGISTRAR DATE JAN 24 '61	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Fries	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

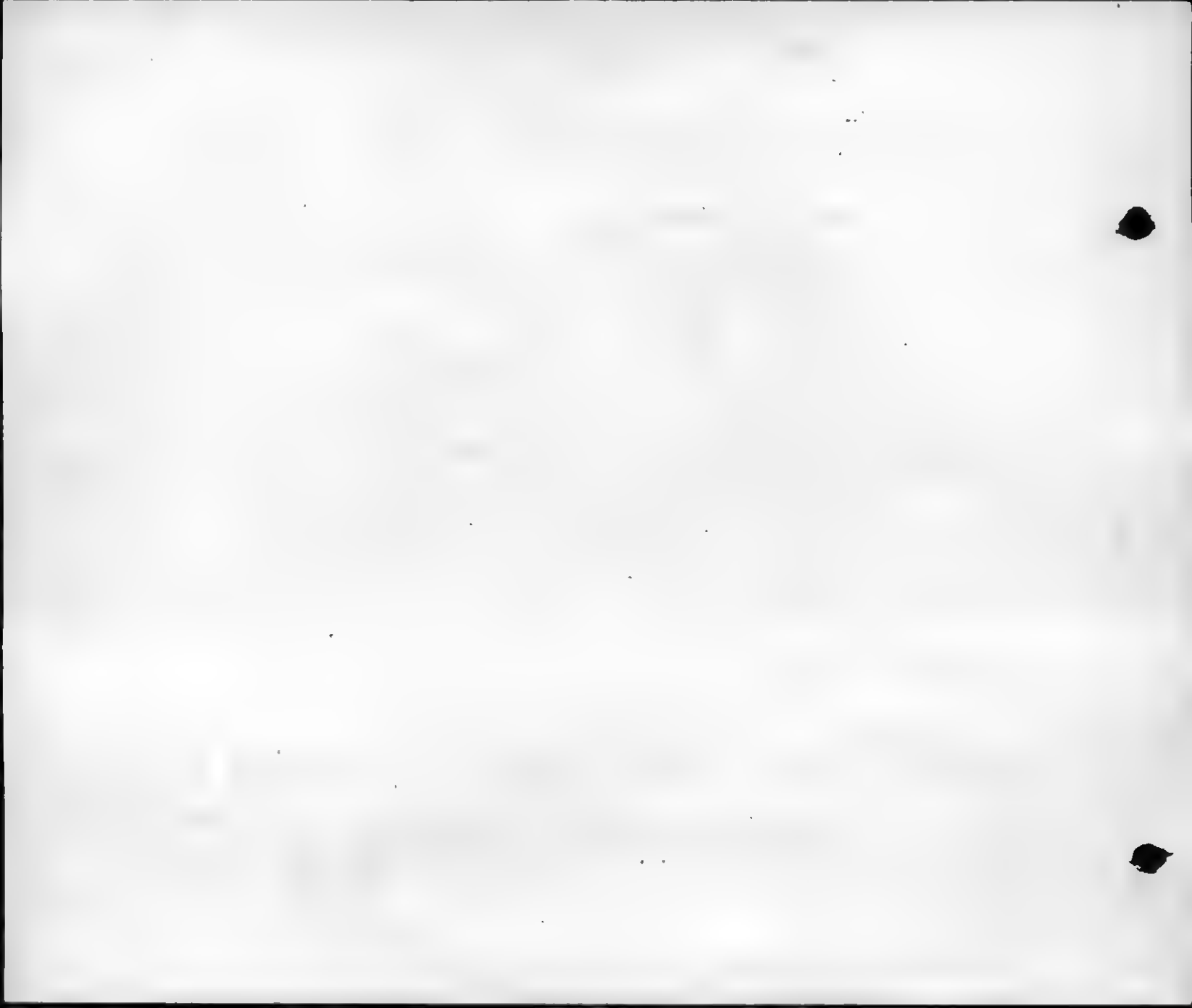
VR A15 (4)
15M 9/59

425

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60423

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN 1b 4y 7m 00d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2653 Miles Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Francis Last Blake		4. DATE OF DEATH Month 1 Day 13 Year 1961	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-81 9 AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Blake		14. MOTHER'S MAIDEN NAME Mary J. Kavenoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17 INFORMANT Hospital Records		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized arteriosclerosis 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emboli, right pulmonary artery DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH more than 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Septem. 1960 to Jan. 13, 1961 , that (I) (we) last saw the deceased alive on Jan 13, 1961 , and that death occurred at 1:20 M, from the causes and on the date stated above.			
22a. SIGNATURE Yasuo Takahashi M.D.		22b. DATE SIGNED 1-13-61	
22c. PHYSICIAN'S NAME (Type) Yasuo Takahashi, M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Old Frederick Rd, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan - 3818 Roland Ave		25a. REC'D BY REGISTRAR JAN 16 '61 25b. REGISTRAR'S SIGNATURE William S. Kline	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00424

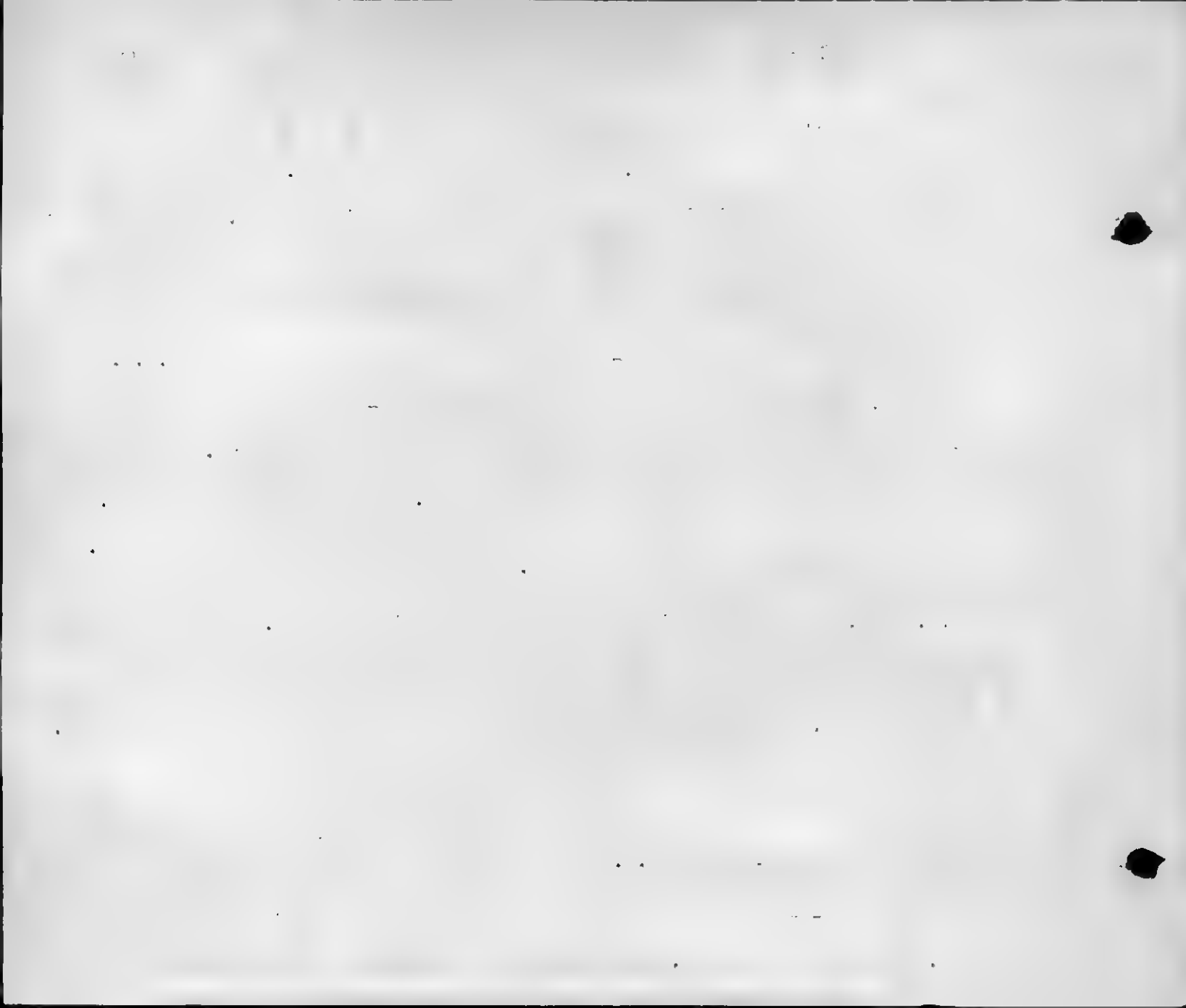
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>2mos. 27days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm. sion) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18.</u> d. STREET ADDRESS <u>3016 Guilford Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>Potter</u> Last <u>Bowlus</u>				4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 19, 1876</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS last birthday) <u>84</u> yrs. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Abraham S. Potter</u>				14. MOTHER'S MAIDEN NAME <u>Modessa - Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Springfield Hospital Records.</u>				Address <u>-</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia.</u> DUE TO <u>2X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple infarcts in brain, probably due to arteriosclerosis.</u> DUE TO <u>-</u> (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>C.B.S. assoc. with senile brain disease with psychotic reaction.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Approx. 9/15/60</u> p.m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unknown</u>		20f. (City or town) <u>Baltimore</u> (County) <u>City</u> (State) <u>Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>-</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-9-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>John O. Mitchell & Sons, Inc. 1900 Eutaw Place</u>				24a. REC'D BY REGISTRAR <u>JAN 9 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
Days. -
Weeks. -

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

DATE SIGNED
1/5/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

427

427

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00425

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2mos. 4days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		d. STREET ADDRESS -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Franklin Last Brashears		4. DATE OF DEATH Month January Day 18 , Year 1961	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1875
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 05 Days 05 Hours 05 Min. 05	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Brashears		14. MOTHER'S MAIDEN NAME Charlotte Peterman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic cardiovascular disease. DUE TO (c) Coronary artery disease.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis.			
INTERVAL BETWEEN ONSET AND DEATH 2 weeks. Years Years.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1960 to Jan. 18, 1961 , that (I) (we) last saw the deceased alive on Jan. 18, 1960 , and that death occurred at 8:30PM from the causes and on the date stated above			
22a. SIGNATURE Agustin del Campo, M.D.		22b. DATE SIGNED 1/19/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/21/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md.		25a. REC'D BY REGISTRAR DATE JAN 23 '61	
25b. REGISTRAR'S SIGNATURE C. S. Kline			



CERTIFICATE OF DEATH

Reg. Dist. No. 60426

428

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 2 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION JORDAN'S REST HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR MD. RD #1 d. STREET ADDRESS MEDFORD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUSAN REBECCA BROTHERS First Middle Last 4. DATE OF DEATH JAN. 3 1961 Month Day Year		5. SEX F. 6. COLOR OR RACE W. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH JULY 27 1878 9. AGE (In years last birthday) 82 yrs IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) CARROLL CO. MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EZRA ROUTZOHN 14. MOTHER'S MAIDEN NAME SARAH PETRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. 15-041-454 INFORMANT MRS. NEVIN DUTROW, INT. UNION, MD. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocarditis & degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis General Hypertension DUE TO (b) 5-6 yrs DUE TO (c) 5-6 yrs INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1959 to Jan. 1960 , that I last saw the deceased alive on Jan. 1960 , and that death occurred at Westminster, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 1/3/61			
ACTUAL SIGNATURE W. L. Speicher		DATE SIGNED 1/3/61	
PHYSICIAN'S NAME (Type) W. L. Speicher			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/5/61	
22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Rural		22d. LOCATION (City, town, or county) (State) Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr.		24a. REC'D BY REGISTRAR JAN 6 1961 DATE	
ADDRESS Westminster, Md.		24b. REGISTRAR'S SIGNATURE Charles E. Frank	

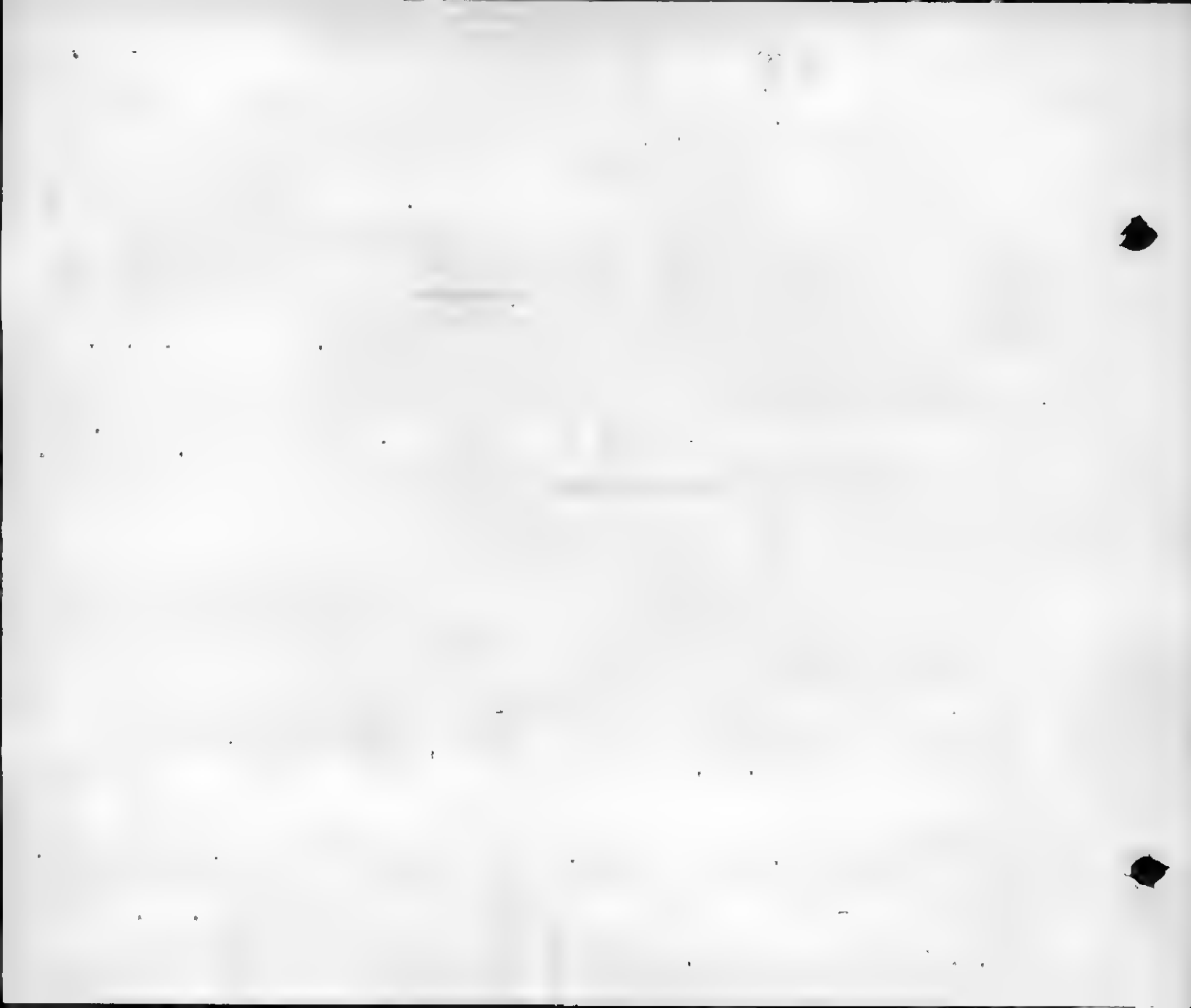
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
429
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00427

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 313 days			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 29 S. Court Street			
3. NAME OF DECEASED (Type or print) First Middle Last Eugene Augustus Brown				4. DATE OF DEATH Month Day Year January 14 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-22-1900	
9. AGE (In years last birthday) 60 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles Brown				14. MOTHER'S MAIDEN NAME Maryetta Temple			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 214-10-5186		17. INFORMANT Address Frederick-Md. 29 S. Court St. Eugene A. Brown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> Cardiovascular insufficiency 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input checked="" type="checkbox"/> Cancer of the lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 7, 1960 to January 14, 1961 , that (I) (we) last saw the deceased alive on Jan. 14, 1961 , and that death occurred at 7: P M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Edgars M Maculans</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans, Supt.				22d. ADDRESS Henryton State Hospital, Henryton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-61		23c. NAME OF CEMETERY OR CREMATORY Bartonsville		23d. LOCATION (City, town, or county) (State) Frederick Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.E. Hicks 111 Frederick, Maryland				25a. REC'D BY REGISTRAR DATE JAN 18 '61		25b. REGISTRAR'S SIGNATURE <i>John S. Francis</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

430

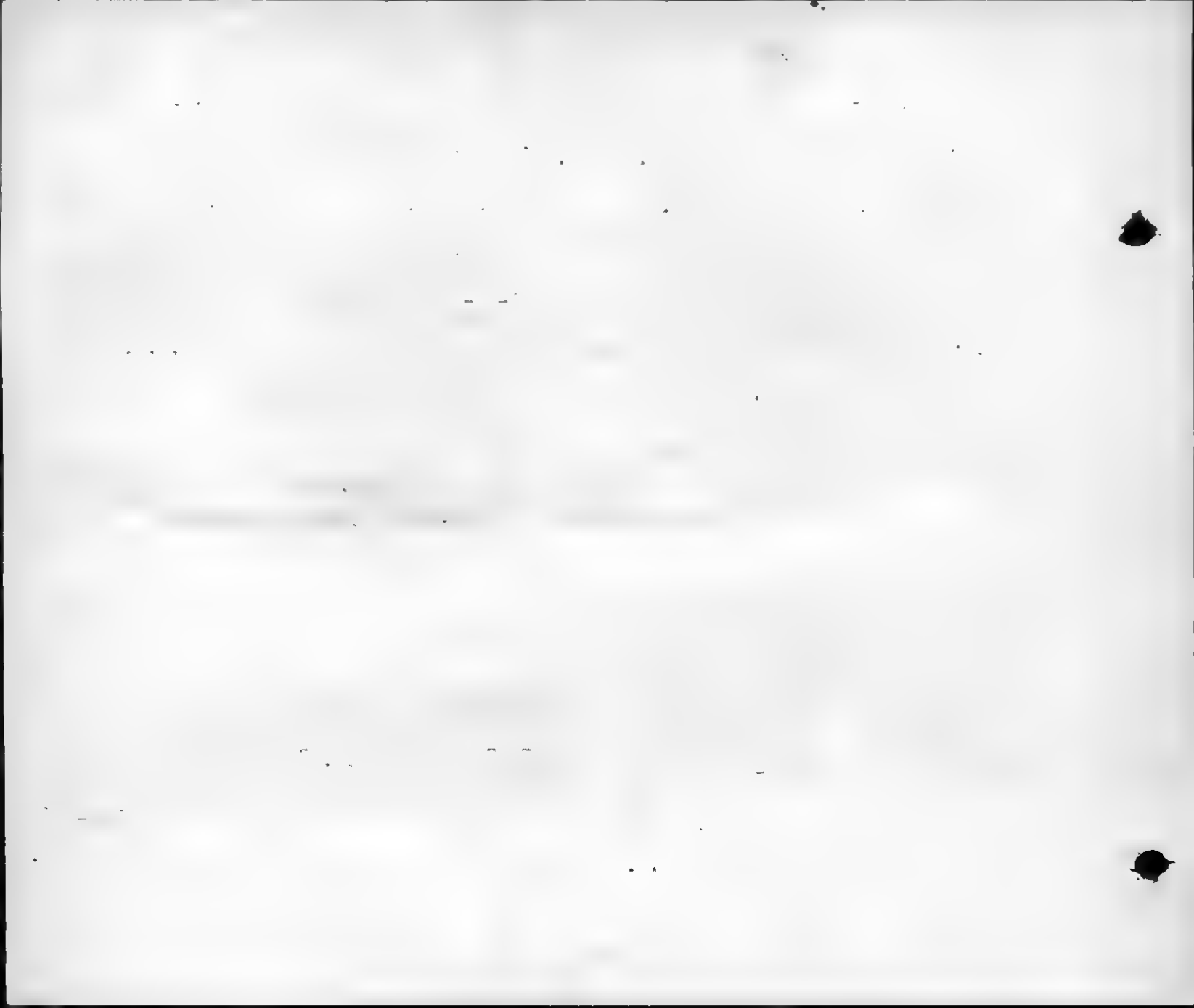
44

515

60423

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY (If in hospital, write) 12yrs.7mths.21days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 3907 Pinewood Ave. (Overlea) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mabel Middle Myrtle Last Brown		4. DATE OF DEATH Month 1 Day 1 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1894
9. AGE (in years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min. 15	11. IF UNDER 24 HRS Months 6 Days 1 Hours 1 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Lee Brown		14. MOTHER'S MAIDEN NAME Anna Mary Steigewald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Un known (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Lung Abscesses DUE TO Aspiration Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration (c) Bronchopneumonia PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic simple type		INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-15-60 , 19 61 , that (I) (we) last saw the deceased alive on 1-1- 19 61 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE Agustin del Campo M.D. 22b. DATE 1-1-1961 22c. PHYSICIAN'S NAME (Type) Agustin del Campo M.D. 22d. ADDRESS Springfield State Hospital Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/4/61	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION (City, town, or county) (State) BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassala Funeral Home		25a. REC'D BY REGISTRAR DATE JAN 4 '61	
ADDRESS 7901 Belair Road #6 MD.		25b. REGISTRAR'S SIGNATURE William J. Pines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

431

60429

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9 Webster St.</u>				d. STREET ADDRESS <u>9 Webster St.</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE LEE BROWN</u>				4. DATE OF DEATH Month Day Year <u>Jan 24 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17 1886</u>	9. AGE (n years last birthday) <u>74</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Westminster, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Lawrence Graft</u>				14. MOTHER'S MAIDEN NAME <u>Alice Jane Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Mrs Mrs B. Keyser</u> Address <u>9 Webster St. Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420. Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of stomach</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 21 1955</u> to <u>Jan 24 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 24 1961</u> , and that death occurred at <u>3:45 P.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Julius Chepko</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>				22d. ADDRESS <u>85 E. Queen Westminster Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery Westminster, Md.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>	
				DATE <u>JAN 27 '61</u>			



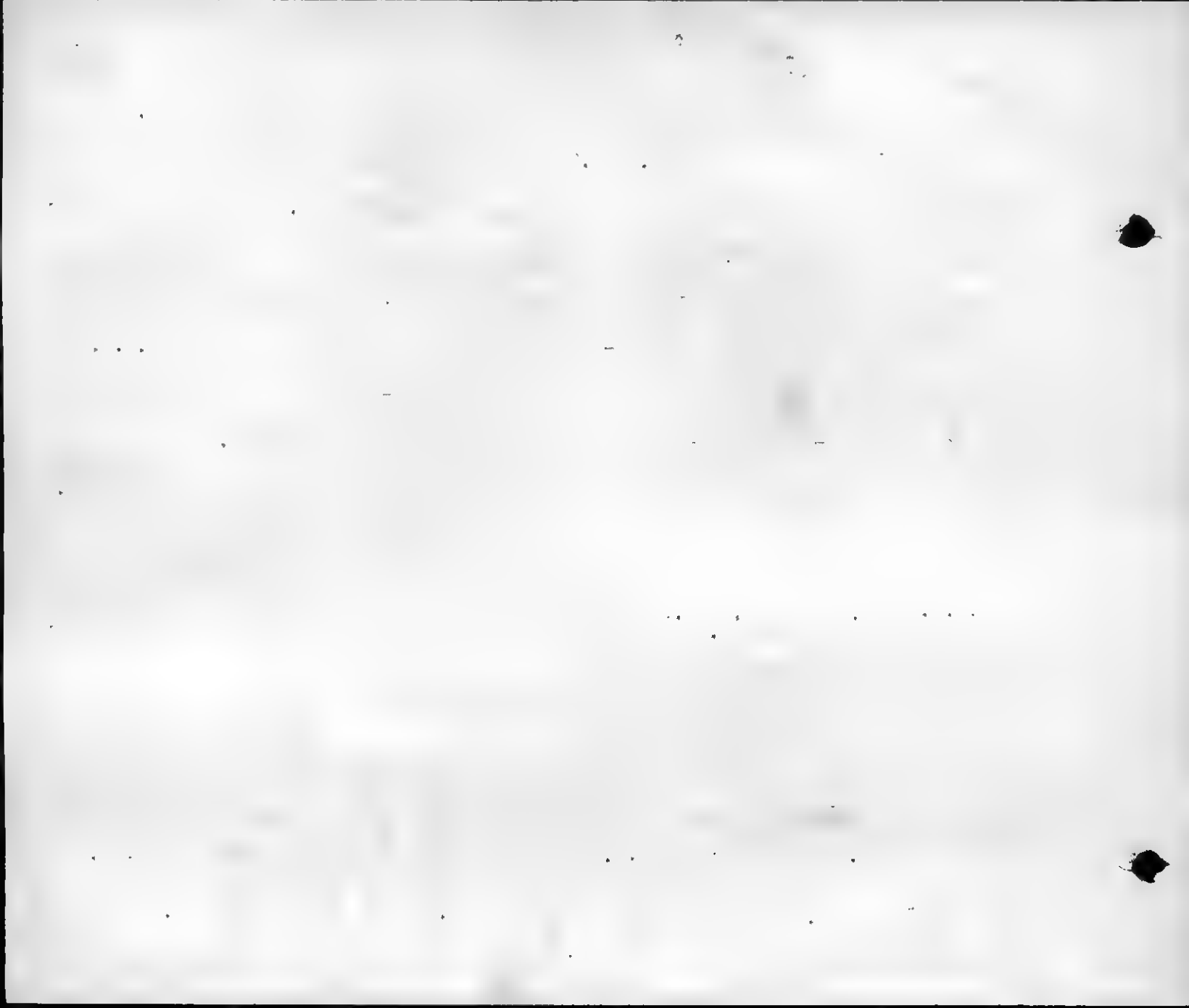
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

432

00430

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE Maryland b. COUNTY Balto. City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 4yrs. 6mos. 22days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 915 Eastern Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Virginia Middle M Last Lavezza Bruni				4. DATE OF DEATH Month January Day 17, Year 19 61				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 15, 1879		
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min.		IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Lavezza				14. MOTHER'S MAIDEN NAME Theresa -				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-05 6074		17. INFORMANT Springfield Hospital Records.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 weeks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a m p m 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 25, 1956 to January 17, 1961 , that (I) (we) last saw the deceased alive on January 17, 1961 , and that death occurred 1:30 PM from the causes and on the date stated above								
22a. SIGNATURE J. Raymond Gladue				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/17/61		
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 21st/61		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Con.		23d. LOCATION (City, town, or county) (State) 4430 Belair Rd.		
24. FUNERAL DIRECTOR'S SIGNATURE Paul DellaNoce				ADDRESS 322 S. High St.		25a. REC'D BY REGISTRAR DATE JAN 20 '61		
				25b. REGISTRAR'S SIGNATURE C. L. K. K. K.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



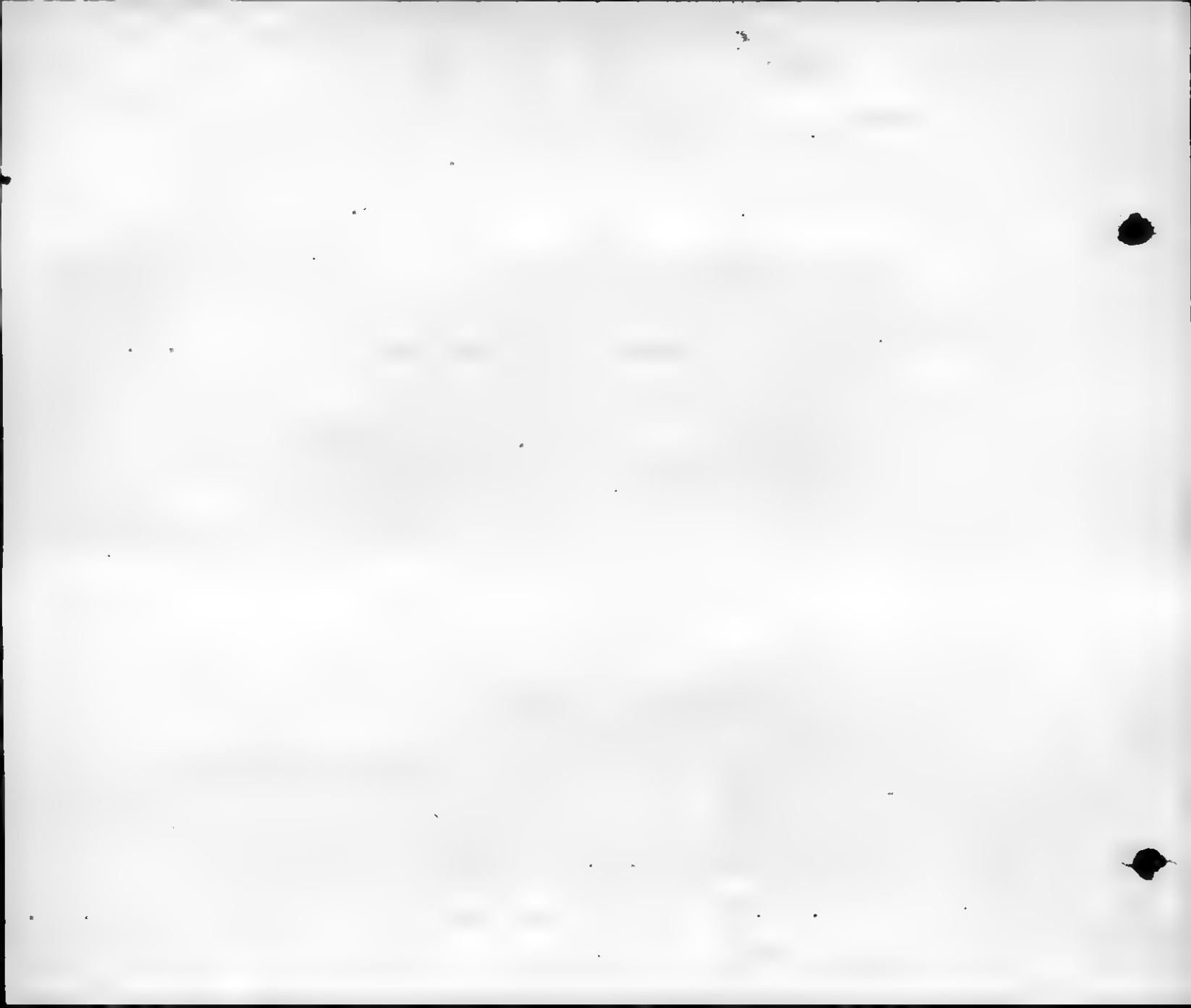
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

CG431

433

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b Mt. Airy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SARAH SAUBLE BUSHEY				4. DATE OF DEATH Month January Day 9 Year 1961			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1873	
9. AGE (In years last birthday) 87 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME George W. Mullinix			
14. MOTHER'S MAIDEN NAME Margaret Mount				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Mr. Harry L. Bushey, Same as No. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, hypertension, arteriosclerosis 34x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertension, arteriosclerosis DUE TO (c) arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 1959 TO 1961
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1959 to 9 Jan 1961 , that (I) (we) last saw the deceased alive on 9 Jan 1961 , and that death occurred at 11:30 M. from the causes and on the date stated above.							
22a. SIGNATURE Howard E. Hall				22b. DATE 10 Jan 61		22c. PHYSICIAN'S NAME (Type) Howard E. Hall M. D.	
22d. ADDRESS Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 12, 1961		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City, town, or county) (State) Westminster, Carroll, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland				25a. REC'D BY REG-STRAR JAN 12 '61		25b. REGISTRAR'S SIGNATURE William S. Hume	

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

434

CERTIFICATE OF DEATH

Items 4, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

10403

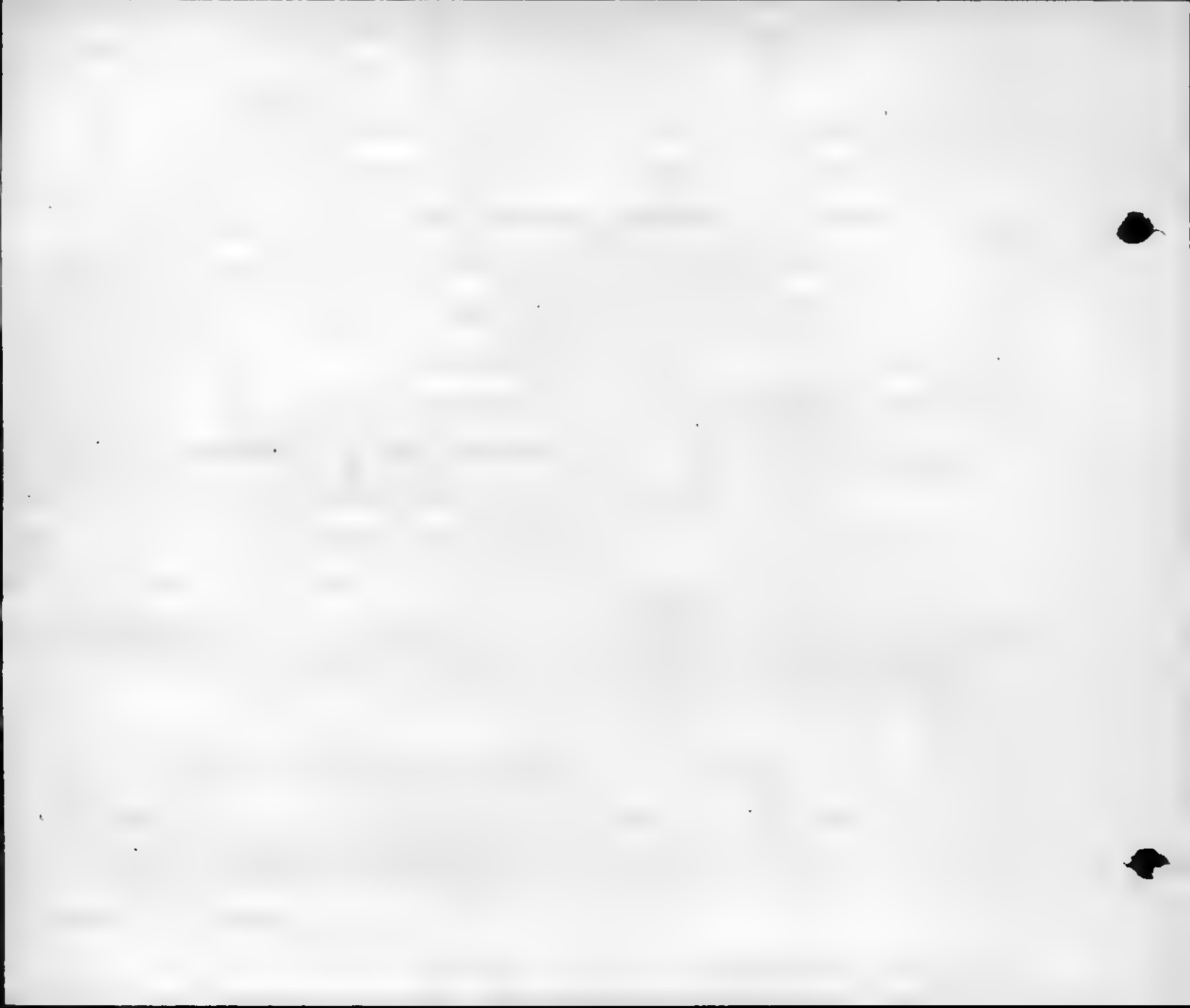
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>	
c. LENGTH OF STAY IN 1b <u>since 6-5-59</u>		d. STREET ADDRESS <u>4264 Cherry Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield St. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>Coster</u> Last <u>Coster</u>		4. DATE OF DEATH <u>January 8, 1961</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1874</u>
9 AGE (In years last birthday) <u>86</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John K. Coster</u>		14. MOTHER'S MAIDEN NAME <u>Lyla</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Records of Springfield Hospital</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>334 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia</u> DUE TO (c) <u>CBS. prev. with cerebral atrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-5-1959</u> to <u>1-7-1961</u> , that (I) (we) last saw the deceased alive on <u>1-7-1961</u> , and that death occurred at <u>1:50 p.m.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Myron Nizankowsky</u> M.D.		22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>Myron Nizankowsky</u>		22d. ADDRESS <u>Springf. State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 10/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPHS</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO MDE</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Josephine Fernald Howe</u>		25a. REC'D BY REGISTRAR <u>—</u> DATE <u>JAN 10 '61</u>	
ADDRESS <u>7401 Belair Rd #6</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Hanna</u>	



00433

VR A15 (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution- Res dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jordan-Rice Home</u>		d. STREET ADDRESS <u>Wheaton</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>CUSHING</u> Last <u>1</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Magdalene Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Dr. Harry Jones, Wheaton, Md.</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arterio Sclerosis General</u> DUE TO (c) <u>Hypertension + Myocardial Degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>General</u> INTERVAL BETWEEN ONSET AND DEATH <u>120</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUT NOT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 29 1960</u> to <u>Jan 1 1961</u> that (I) (we) last saw the deceased alive on <u>Dec 29 1960</u> and that death occurred at <u>1:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Glenn Speicher</u>		22b. DATE <u>Jan 2-1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. Glenn Speicher</u>		22d. ADDRESS <u>Wheaton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheaton Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Wheaton Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Glenn Speicher</u>		25a. REGISTERED BY REGISTRAR DATE <u>JAN 4 61</u>	
25b. REGISTRAR'S SIGNATURE <u>W. Glenn Speicher</u>		25c. REGISTRAR'S SIGNATURE <u>W. Glenn Speicher</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
436 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 60434									
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN 1b <u>1 HOUR</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MAIN ST. EXT</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>GEORGE AUGUSTUS DANNER</u> First Middle Last 4. DATE OF DEATH <u>JAN 23 1961</u> Month Day Year 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Nov 26 - 1915</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>45</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.					10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKING</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>AUGUSTUS DANNER</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>420-0-1</u> 17. INFORMANT <u>DOROTHY DANNER</u> Address <u>RURAL NEW WINDSOR MD</u>					14. MOTHER'S MAIDEN NAME <u>FLORENCE A DANNER</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>min</u> <u>month</u>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED <u>1/23/61</u>									
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D. EXAMINER'S NAME (Type or print) <u>JAMES T. MARSH</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>1/24/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u> 22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>									
23. FUNERAL DIRECTOR <u>W. H. Hartley & Sons, New Windsor, Md</u> ADDRESS 24a. REC'D BY REGISTRAR <u>DATE JAN 27 '61</u> 24b. REGISTRAR'S SIGNATURE <u>William E. Hume</u>									



437

CERTIFICATE OF DEATH

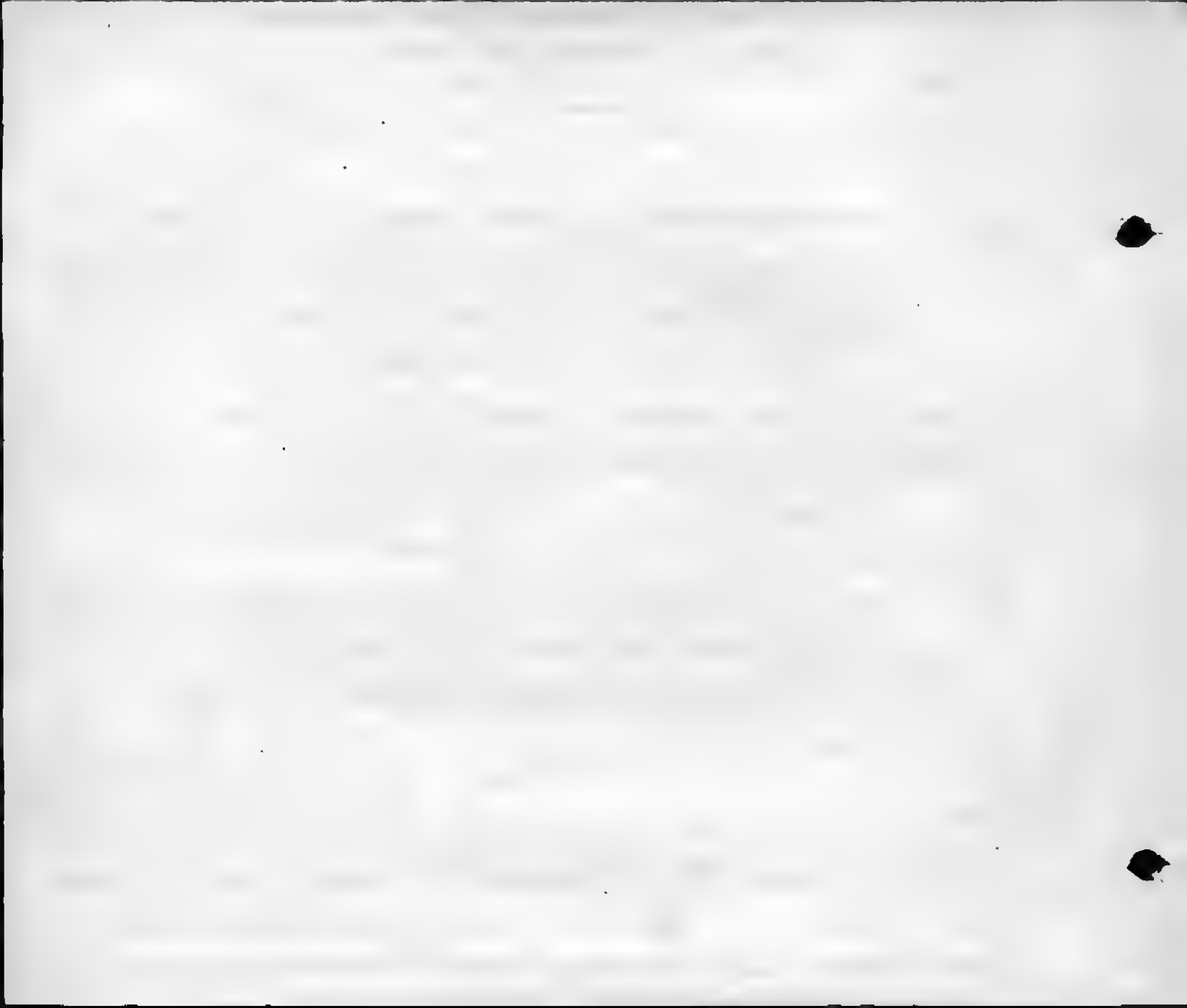
Reg. Dist. No. 60435

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
c. LENGTH OF STAY IN 1b <u>18 yrs</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>47 E. Main St.</u>			
e. STREET ADDRESS <u>47 E. Main St.</u>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET AGNES DONNELLY</u>				4. DATE OF DEATH <u>January 24 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 29 1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt. Manufacturing (Worker)</u>		11. BIRTHPLACE (State or foreign country) <u>Allegheny Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Donnelly</u>				14. MOTHER'S MARDEN NAME <u>Roseanne Dabney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(1) yes, give war or date of service</u>				16. SOCIAL SECURITY NO. <u>212-24-6301</u>			
17. INFORMANT <u>Miss Catherine Donnelly, Same address</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several hrs</u> <u>Several yrs</u> <u>Several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 20 1960</u> to <u>Jan 24 1961</u> , that I last saw the deceased alive on <u>Jan 20 1961</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wylene Speicher Westminster Md</u>				DATE SIGNED <u>1/25/61</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/27/61</u>		<u>Old Town Cemetery</u>		<u>Rural Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JAN 27 '61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

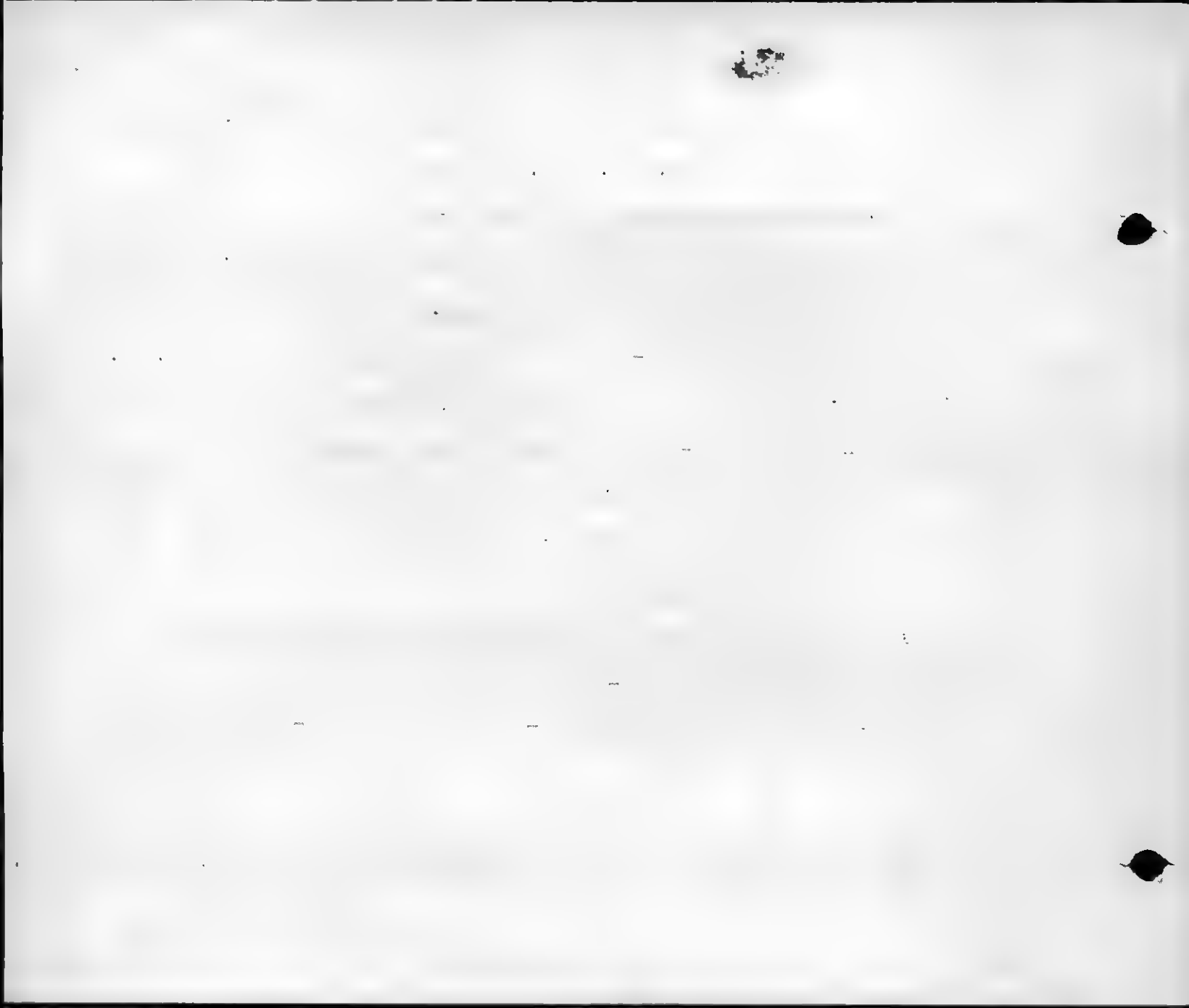
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

438

CERTIFICATE OF DEATH

00456

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr. 5mos. 14das.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS -			
3. NAME OF DECEASED (Type or print) First John Middle Noland Last Downs				4. DATE OF DEATH Month January Day 23 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-84	9. AGE (In years lost birthday) 76 yrs	IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Downs				14. MOTHER'S MAIDEN NAME Linnie Dove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO -		17. INFORMANT Address Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH 4 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with cerebral arteriosclerosis with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Month, Day, Year Hour a. m. - p. m. - 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that (I) (this hospital) attended the deceased from 8-10-1959 to 1-23-1961 , that (I) (we) last saw the deceased alive on 1-23-1961 , and that death occurred at P. M. from the causes and on the date stated above							
22a. SIGNATURE Agustin del Campo M. D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-23-61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo				22d. ADDRESS Springfield State Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/27/61		23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION (City, town, or county) (State) Leesburg MD	
24. FUNERAL DIRECTOR'S SIGNATURE M. A. E. Thomas & Son		ADDRESS Frederick, Md.		25a. REC'D BY REGISTRAR JAN 27 '61		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

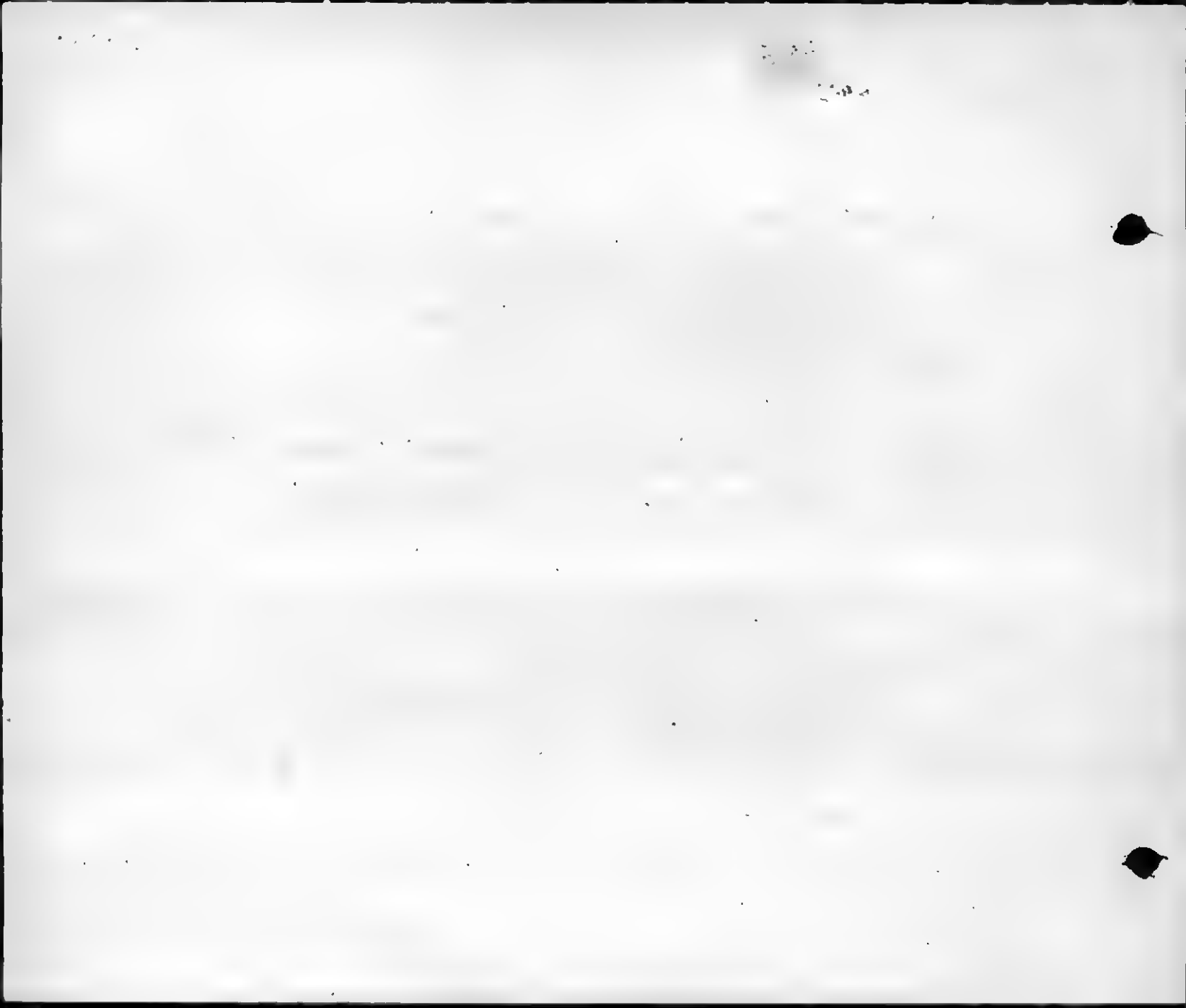


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

439

00457

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>220 South Main St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Nicholas</u> Last <u>Ensor</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 25, 1864</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Ensor</u>				14. MOTHER'S M maiden name <u>Sarah Bantley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Mr. Elmer E. Manchester</u> Address <u>Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>432.1</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>?</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day Year Hour <u>0</u> m <u>0</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1960</u> to <u>January 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>January 13, 1961</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush MD</u>				22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>	
				22d. ADDRESS <u>Hampstead Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-19-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Lutheran</u>		23d. LOCATION (City, town, or county) <u>Baltimore Md</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edell H. Tipton, Hampstead Md</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	



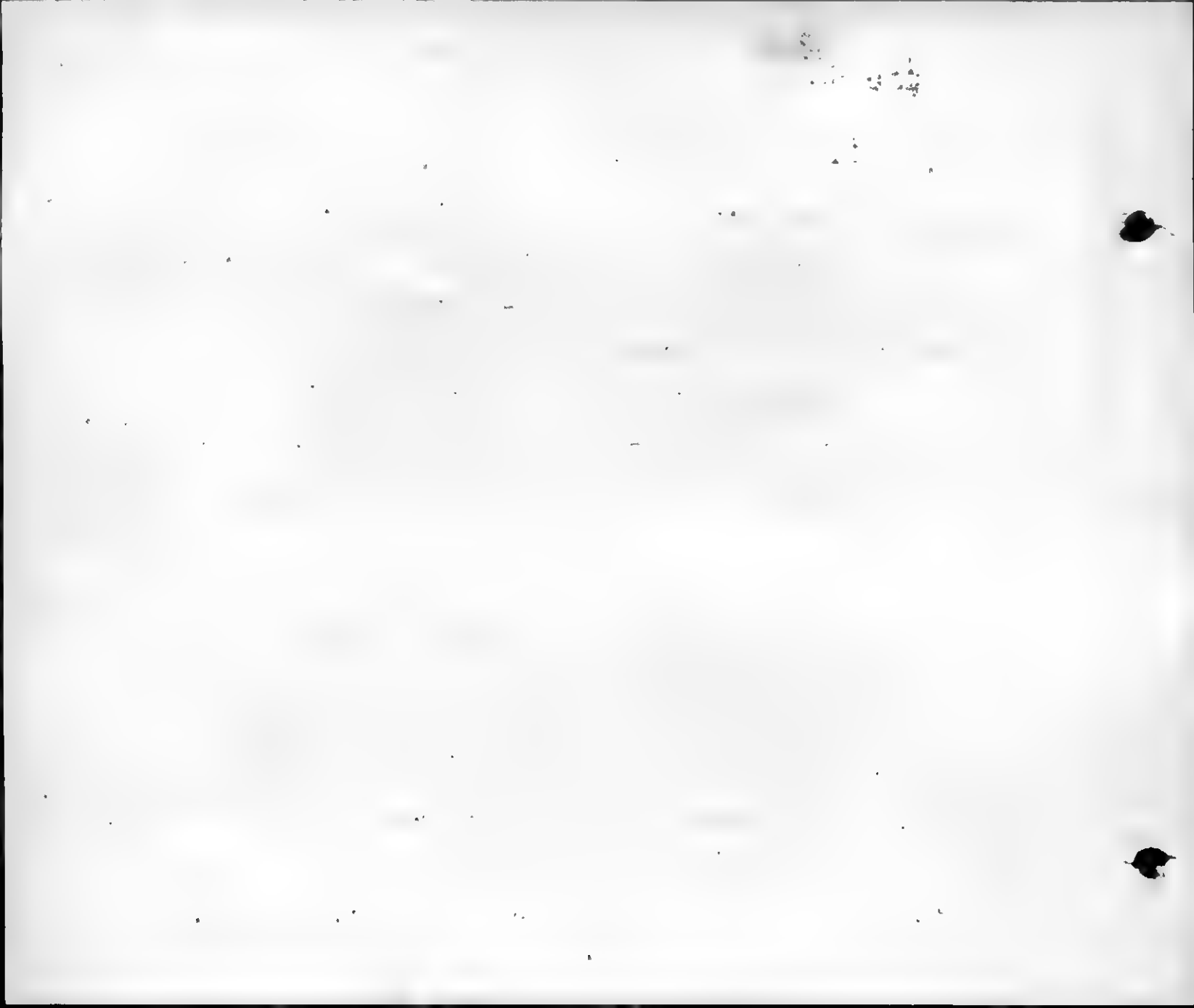
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **00438**

1. PLACE OF DEATH o COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle ETCHISON Last		4. DATE OF DEATH Month Jan. Day 13, Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7--15-1888
9. AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Wesley Etchison	
14. MOTHER'S MAIDEN NAME Frances Hood		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) --	
16. SOCIAL SECURITY NO. 215-32-3342		17. INFORMANT H. Leonard Etchison, 406 Oak Court, Balto. 28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 10/30, 1958 to 1/13, 1961 , that I last saw the deceased alive on 1/8, 1961 , and that death occurred at A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) W. M. D. Llanowes, Md.	
PHYSICIAN'S NAME (Type) JAMES P. KERR		DATE SIGNED 1/14/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-16-1961	22c. NAME OF CEMETERY OR CREMATORY Pine Grove	22d. LOCATION (City, town, or county) (State) Mt. Airy, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE JAN 17 '61		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

441

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00439

Items 13, 14 Film 2-15-61 et

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN lb 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anne Persis Fenlon		4. DATE OF DEATH Month Day Year January 31, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1889
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Fox Stevens		14. MOTHER'S MAIDEN NAME Emeline Barry Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward Fenlon, Taneytown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Liver 2°, Cancer of Breast DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cancer of Breast DUE TO 10 yrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 24, 1958 to Jan 31, 1961 , that (I) (we) last saw the deceased alive on Jan 27, 1961 , and that death occurred at 2A M. from the causes and on the date stated above.			
22a. SIGNATURE E. Ambler Thompson		22b. DATE SIGNED 2/1/61	
22c. PHYSICIAN'S NAME (Type) E. Ambler Thompson		22d. ADDRESS Taneytown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 3, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City, town, or county) (State) Taneytown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE E.O. Fuss & Son		25a. REC'D BY REGISTRAR DATE FEB 6 '61	
ADDRESS Taneytown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

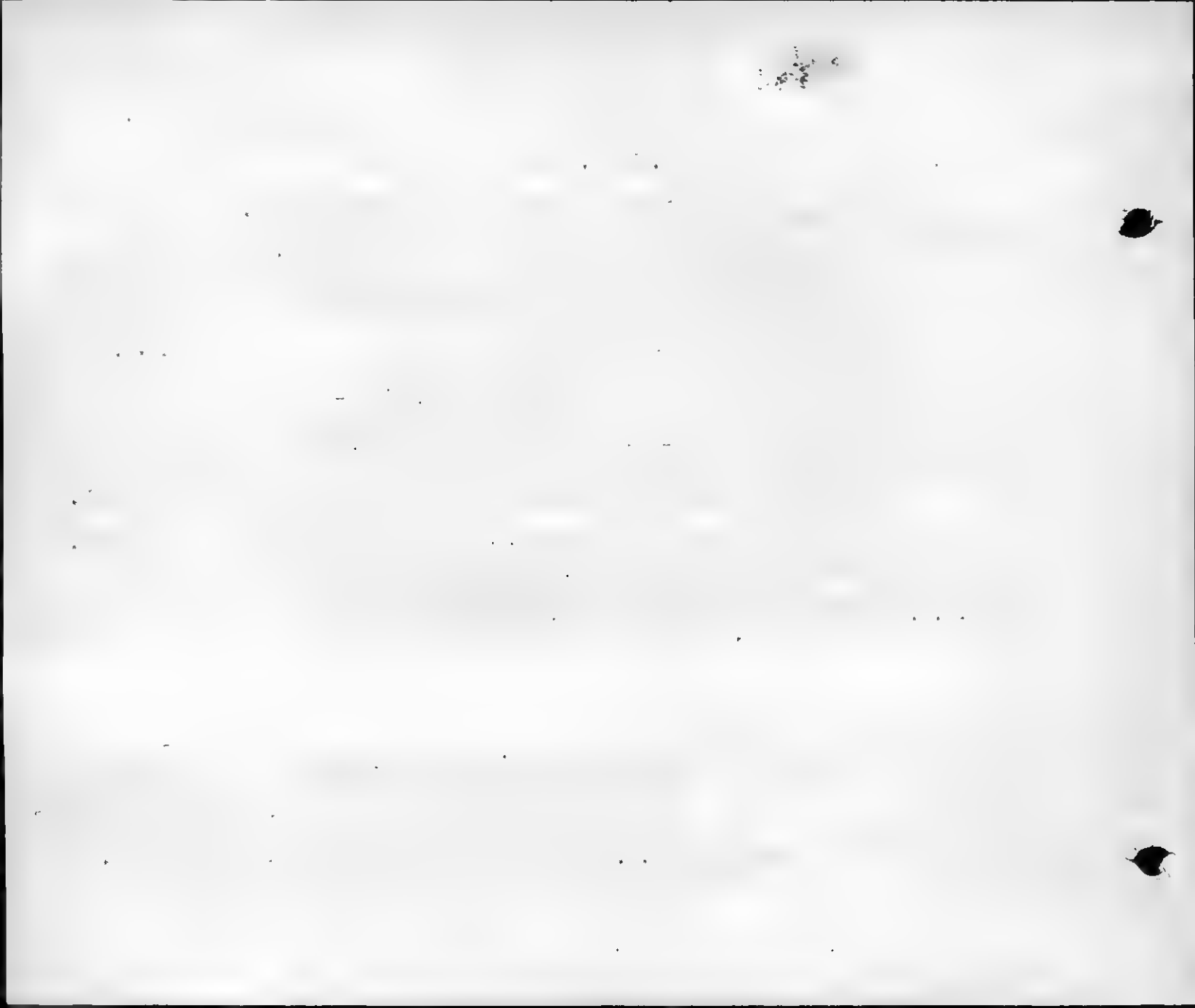
442

00440

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>	
c. LENGTH OF STAY IN 1b <u>6 mos</u>		d. STREET ADDRESS <u>1110 Lund Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha T. Ferlander</u>		4. DATE OF DEATH <u>Jan. 30</u> 19 <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1882</u>
9. AGE (In years, last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>28</u> Hours <u>18</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Saleswoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garment Mfg. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>SPAIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Toledo</u>		14. MOTHER'S MAIDEN NAME <u>not recorded - Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>062-07-659</u>	
17. INFORMANT <u>Harriet Rogers</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Coronary arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome assoc. Senile Brain Disease</u>			19. WAS ALTPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>7-26-1960</u> to <u>1-30-1961</u> , that (1) (we) last saw the deceased alive on <u>Jan. 30, 1961</u> , and that death occurred at <u>4:52 P.M.</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Konstantin Weber</u>		22b. DATE SIGNED <u>1/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Konstantin Weber</u>		22d. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 2/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 6 '61</u>	
ADDRESS <u>11 Raisin Ln. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

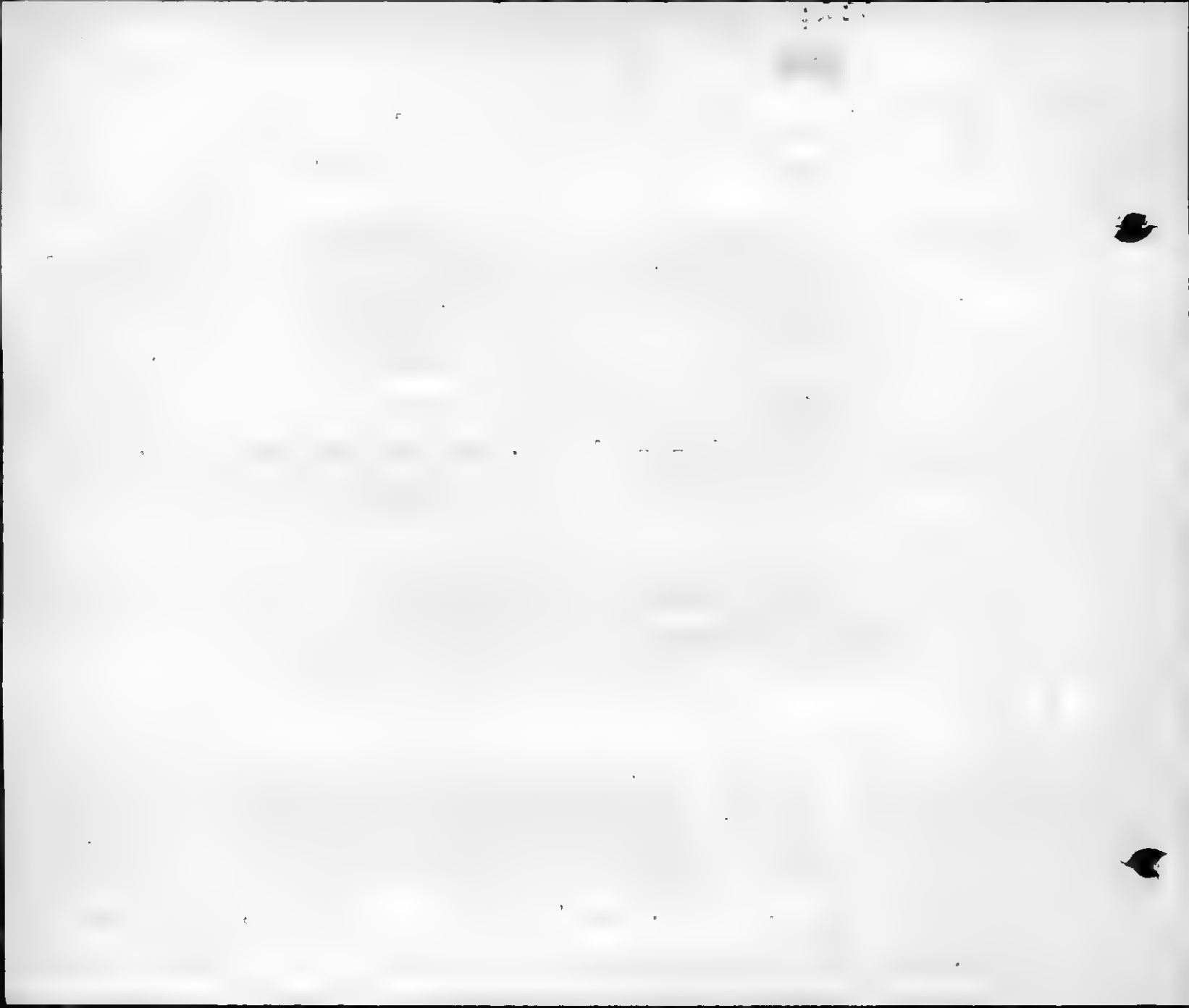
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

444

00442

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>Franklin</u> Last <u>Frock</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 21, 1915</u>	
9. AGE (In years lost birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jesse W. Frock</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Fink</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>160-16-5031</u>		17. INFORMANT <u>Mrs. Catherine Frock, Taneytown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Occlusion</u> <u>120</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Few Min.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>7/6</u> <u>1955</u> to <u>1/15</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> <u>1960</u> and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>R. S. McVaugh</u>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1/16/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>				22d. ADDRESS <u>Taneytown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 18, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. O. Fuss & Son</u>				ADDRESS <u>Taneytown, Maryland</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>				DATE <u>JAN 19 '61</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

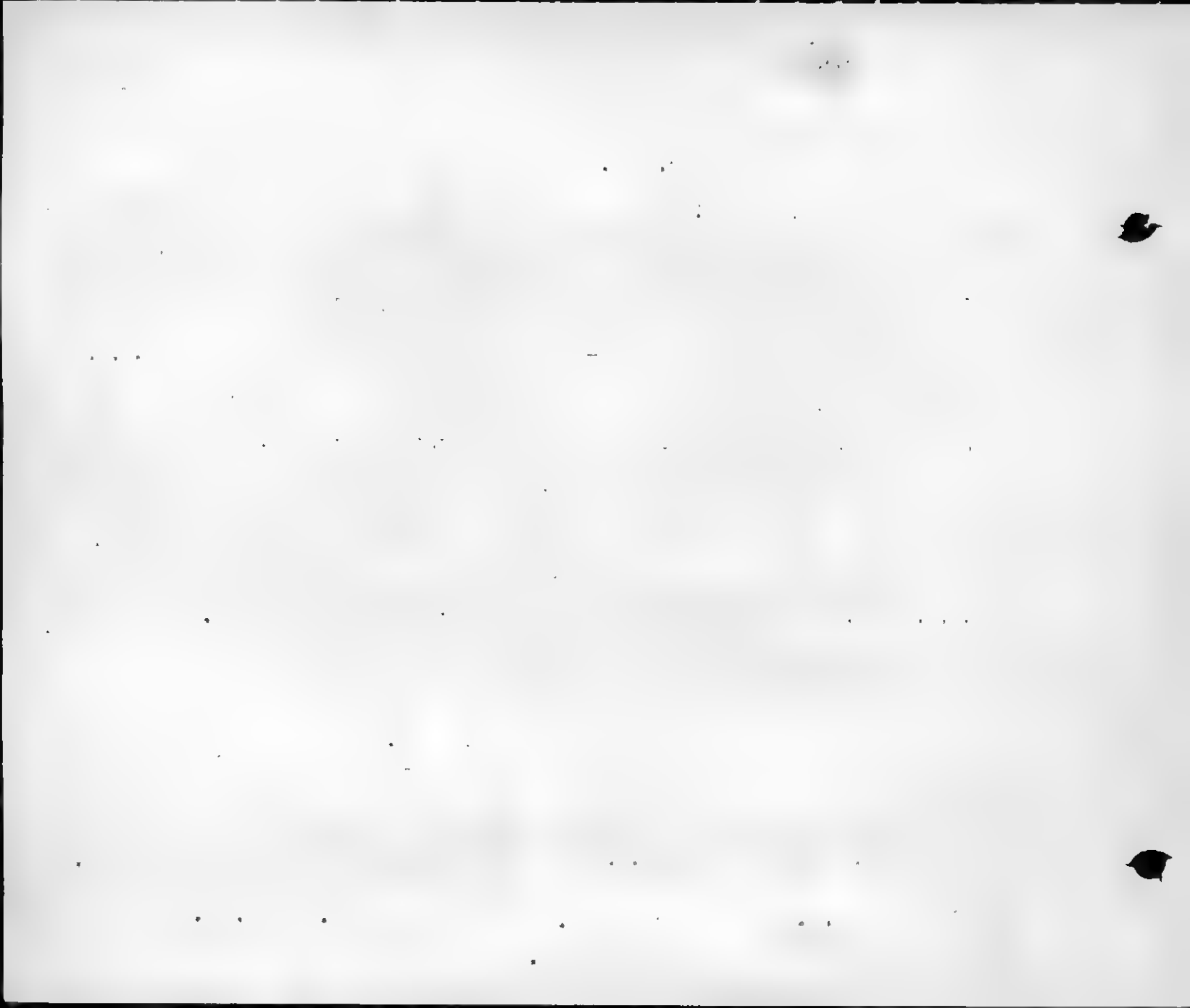
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MARYLAND CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

445

00443

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr.6mos.26days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS R#1			
3. NAME OF DECEASED (Type or print) First Middle Last Fannie Florence Sweeny Geisbert				4. DATE OF DEATH Month Day Year January 13, 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 27, 1881	9. AGE (in years lost birthday) 79 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Sweeny				14. MOTHER'S MAIDEN NAME Amelia Lightner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Renal insufficiency DUE TO (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH Days Weeks -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m p m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 17, 1959 to January 13, 1961 . that (I) (we) last saw the deceased alive on 1/13/1961 , and that death occurred at 8:15AM from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladue M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/13/61			
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1961		23c. NAME OF CEMETERY OR CREMATORY Utica Cem.		23d. LOCATION (City, town, or county) (State) Utica, Fredk. Co. MD	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Brager				25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Howe	



1 FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10444

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HIGH ST</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> d. STREET ADDRESS <u>HIGH ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES MONROE GREEN</u>				4. DATE OF DEATH Month Day Year <u>JAN 26 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 14 - 1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAY WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RUBBER FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>LEWIS E GREEN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BAILE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215 32 4013</u>			
17. INFORMANT <u>LIZZIE GREEN</u>				Address <u>NEW WINDSOR MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIABETES MELLITUS</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>260X</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-26-61</u>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or country) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR <u>L. Hartzler & Sons</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>			
ADDRESS <u>New Windsor</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			
DATE <u>JAN 31 '61</u>							



FOR STATE
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

447 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00445

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b. 5yrs. 3mos. 28days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 5 d. STREET ADDRESS 518 N. Highland Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Mary Catherine Warehime Harman		4. DATE OF DEATH Month January Day 16 Year 19 61		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Month February Day 3 Year 1885		9. AGE (In years last birthday) 75 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Warehime				14. MOTHER'S MAIDEN NAME Jane Warehime				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -				17. INFORMANT Springfield Hospital Records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease. DUE TO (c) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.												INTERVAL BETWEEN ONSET AND DEATH Days 20 Years 0							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient's leg gave way and she fell to floor of ward.															
20c. TIME OF INJURY Month, Day, Year 10:20 AM 12/23/ 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital				20f. (City or town) Sykesville (County) Carroll (State) Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/19/61				22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery Rural Westminister				22d. LOCATION (City, town, or country) (State) Md.							
23. FUNERAL DIRECTOR J. E. Smyer, Jr. Westminister, Md.				24a. RECEIVED BY REGISTRAR JAN 24 1961				24b. REGISTRAR'S SIGNATURE Arthur L. Evans				24c. DATE 1/16/61							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James T. Marsh, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

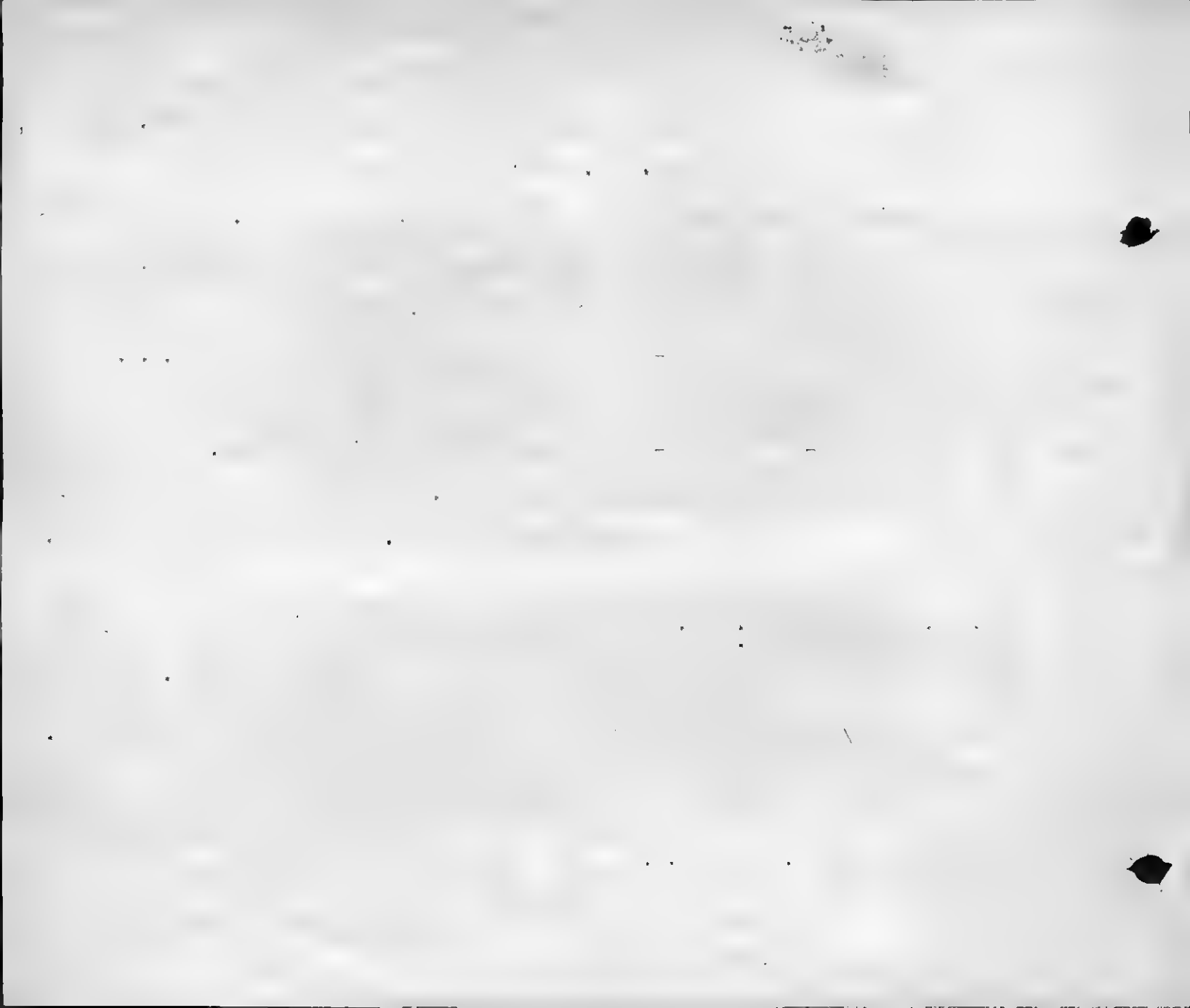
ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

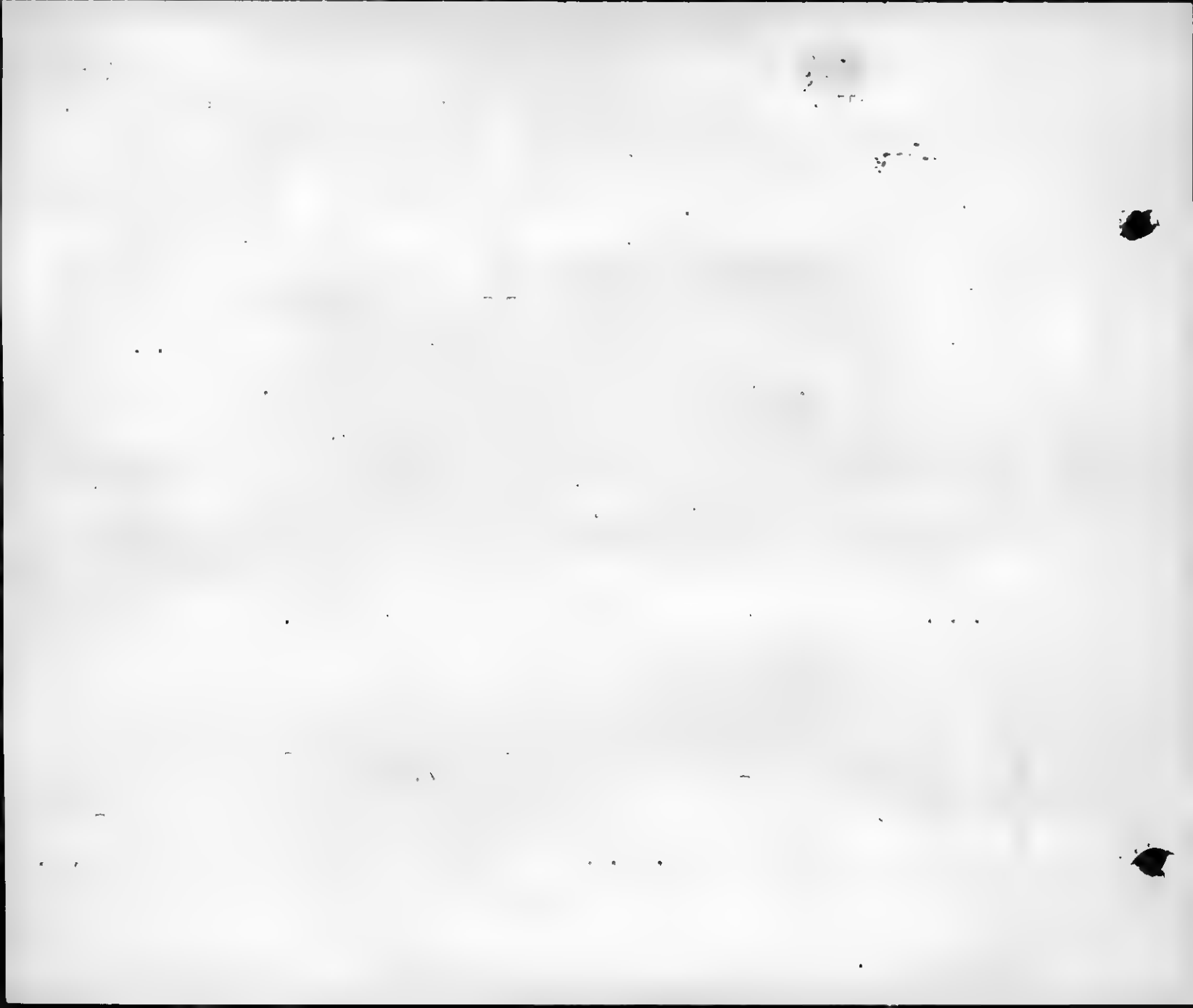
1/16/61



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448
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60446

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington Co. 21 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 512 Cumberland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frisby Middle Tilgman Last Hassett		4. DATE OF DEATH Month 1 Day 1 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1879
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Hassett		14. MOTHER'S MAIDEN NAME Sally J. Couton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease and Nephro-sclerosis Generalized arteriosclerosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) 420.0 DUE TO (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due Cerebral arteriosclerosis with psychotic reactions.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-27-1960 to 1-1-61 , 1961, that (I) (we) last saw the deceased alive on 1-1-1961 , and that death occurred at 9:30P , from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 1-1-1961	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN 5 1961	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE SUPER-ROUZER		25a. REC'D BY REGISTRAR HARPERSTOWN MD	
25b. REGISTRAR'S SIGNATURE W. J. DOWSON		25c. DATE JAN 4 '61	

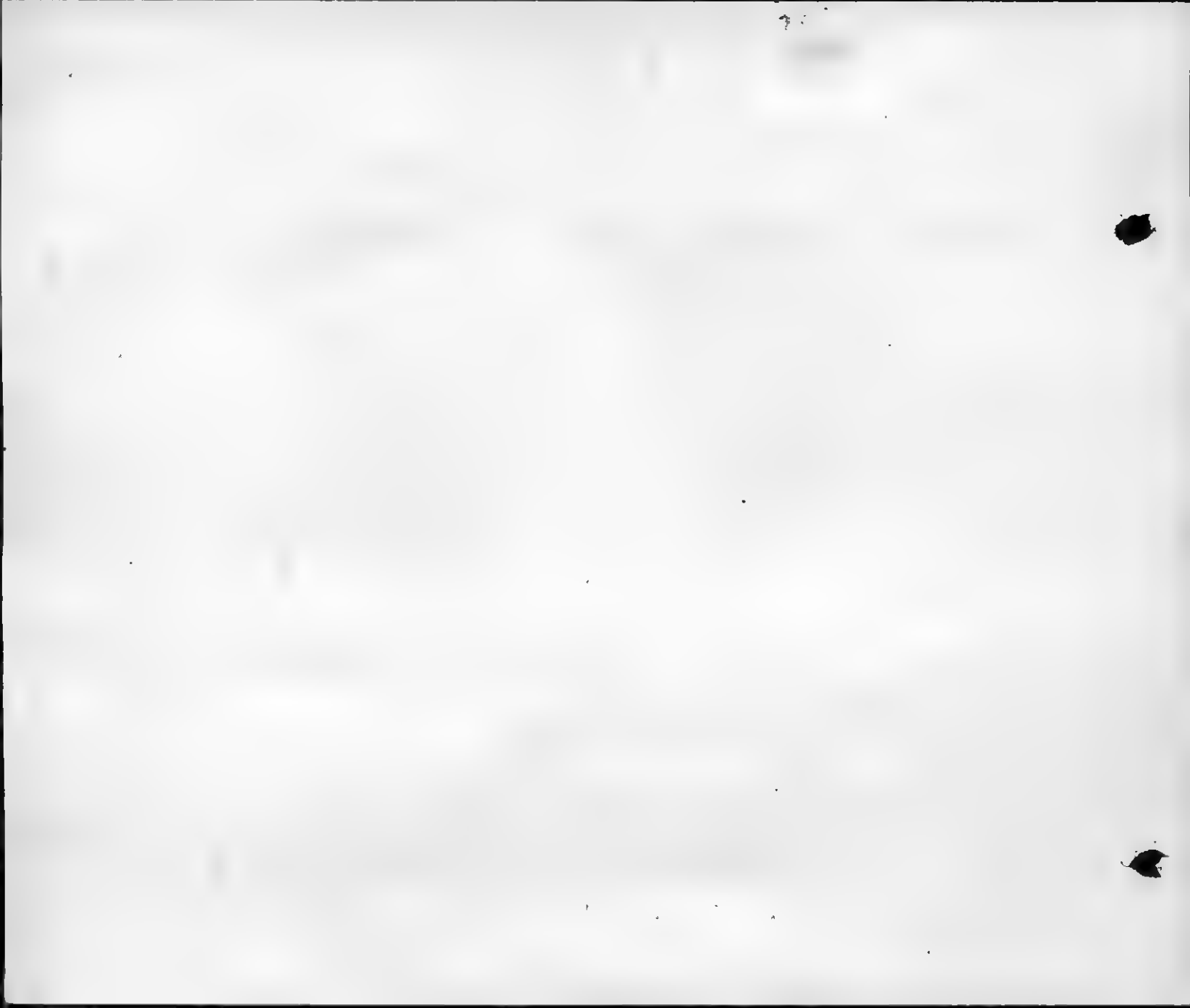


may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

449 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00447

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route #2 Taneytown</u>				e. STREET ADDRESS <u>Pleasant Valley</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Louise Helwig</u>				4. DATE OF DEATH Month Day Year <u>January 24 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 28, 1884</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min. <u>24</u> <u>19</u> <u>61</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aaron Freeland Heltibridle</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Formwalt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Leroy Helwig, 19 Rita Marie, Littlestown, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Occlusion</u> <u>260X</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus, Hemorrhagic Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>few min.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>5/28</u> <u>1960</u> to <u>1/24</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> <u>1961</u> , and that death occurred <u>2:50 P.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R. S. McVaugh</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/25/61</u>		22c. PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>	
22d. ADDRESS <u>Taneytown, Md.</u>							
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 28, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City town, or county) (State) <u>Silver Run, Carroll, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Fuss & Son</u>		ADDRESS <u>Taneytown, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. S. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

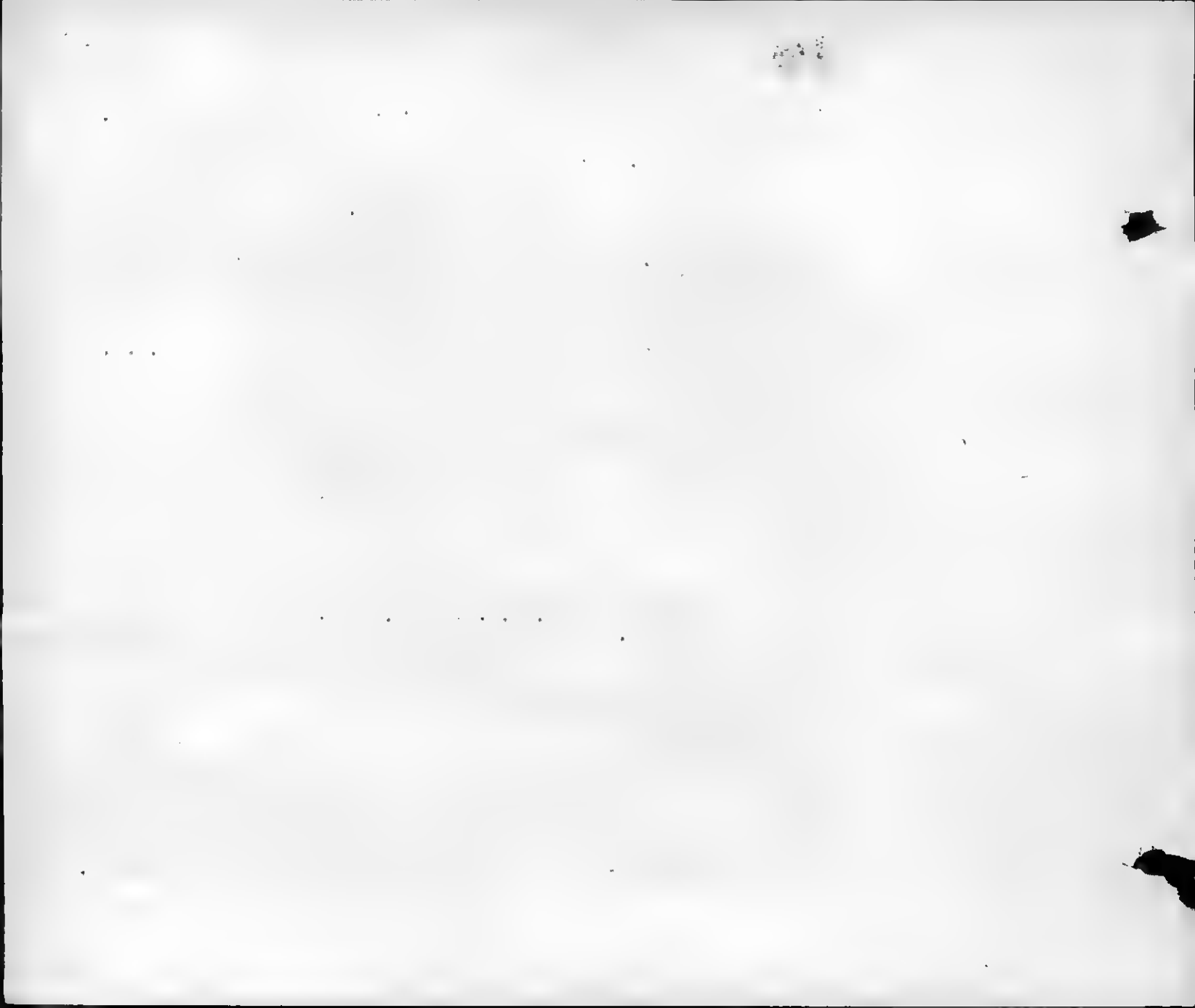
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450

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60448

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5 mos. 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 907 Low St. 31-1-4			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Henry Middle C. Last Hofmann				4. DATE OF DEATH Month January Day 7 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1900		9. AGE (in years last birthday) 60 yrs	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dancer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Hofmann				14. MOTHER'S MAIDEN NAME Adele Chatin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 213-20-3941		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar bilateral pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 490X DUE TO (c) Schizophrenic reaction, catatonic type. C.B.S. assoc. with alcohol intoxication with psychotic reaction.				INTERVAL BETWEEN ONSET AND DEATH days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type. C.B.S. assoc. with alcohol intoxication with psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 18, 1960 to January 7, 1961 , that (I) (we) last saw the deceased alive on January 7, 1961 , and that death occurred at 11:05 AM on the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/7/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/61		23c. NAME OF CEMETERY OR CREMATORY Eastern Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons				ADDRESS Balto 17, Md.		25a. REC'D BY REGISTRAR DATE 11 '61	
				25b. REGISTRAR'S SIGNATURE Wm. J. Lickner			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

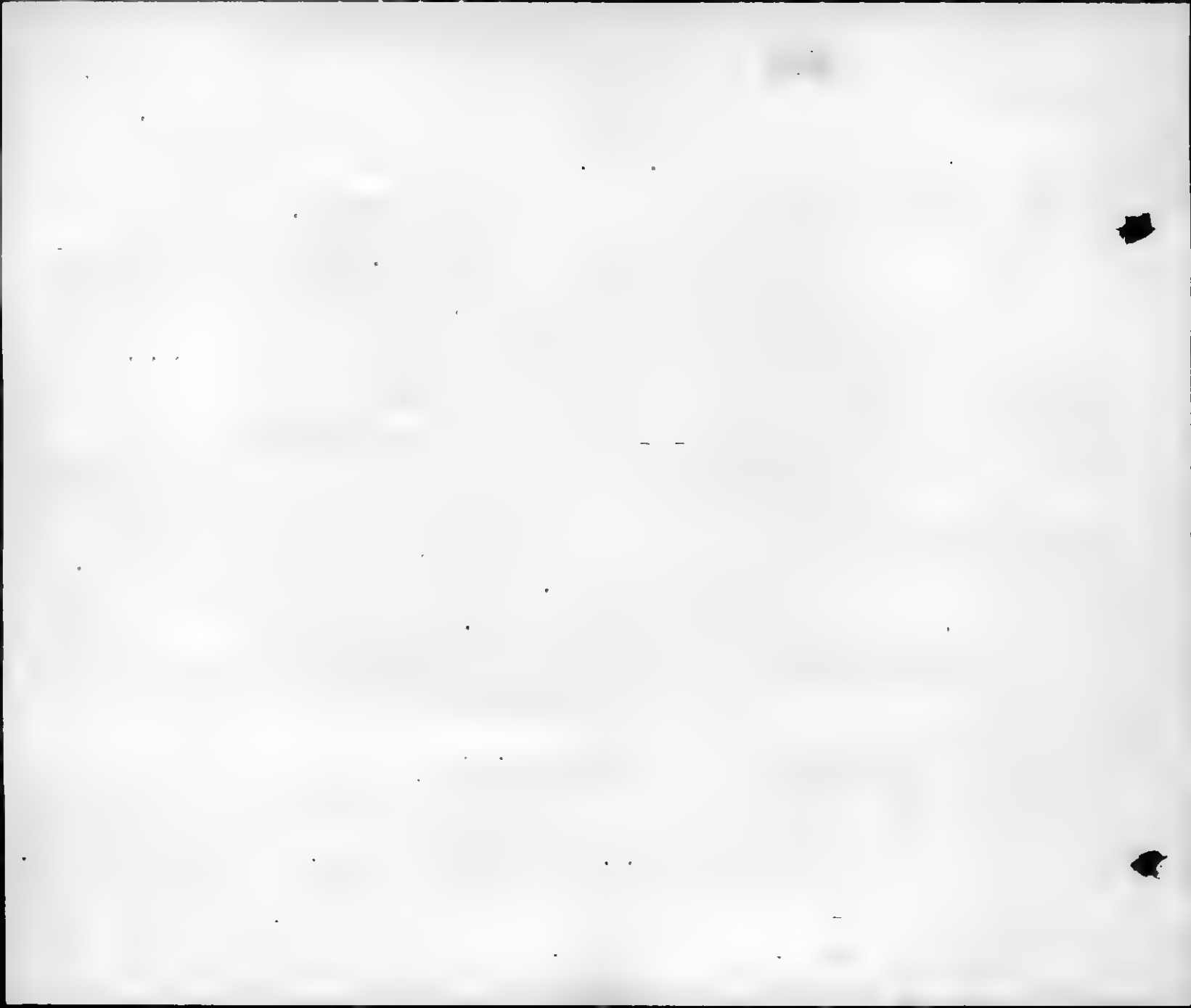
VR A15 (4)
15M 9/59

451

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60449

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1769 Darley St.	
3 NAME OF DECEASED (Type or print) First George Middle Alfred Last Hubbard, Sr.		4. DATE OF DEATH Month January Day 9 Year 1961	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 6 Days 2 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Edward Hubbard		14. MOTHER'S MAIDEN NAME Ida Marie Stalling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-3401	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute purulent meningitis 141.9 DUE TO Infected emboli in carotid artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) Carcinoma of tongue and neck DUE TO (c) Bronchopneumonia.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.B.S. associated with alcohol intoxication.			
INTERVAL BETWEEN ONSET AND DEATH Days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Feb. 1, 1958, to January 9, 1961, that (I) (we) last saw the deceased alive on Jan. 8, 1961, and that death occurred at 6:30 AM from the causes and on the date stated above			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 1/9/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-11-1961	
23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 1901 Eastern Ave.		25a. REC'D BY REGISTRAR DATE JAN 11 '61	
25b. REGISTRAR'S SIGNATURE <i>Celine E. H.</i>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. A15ME
SM 7/59

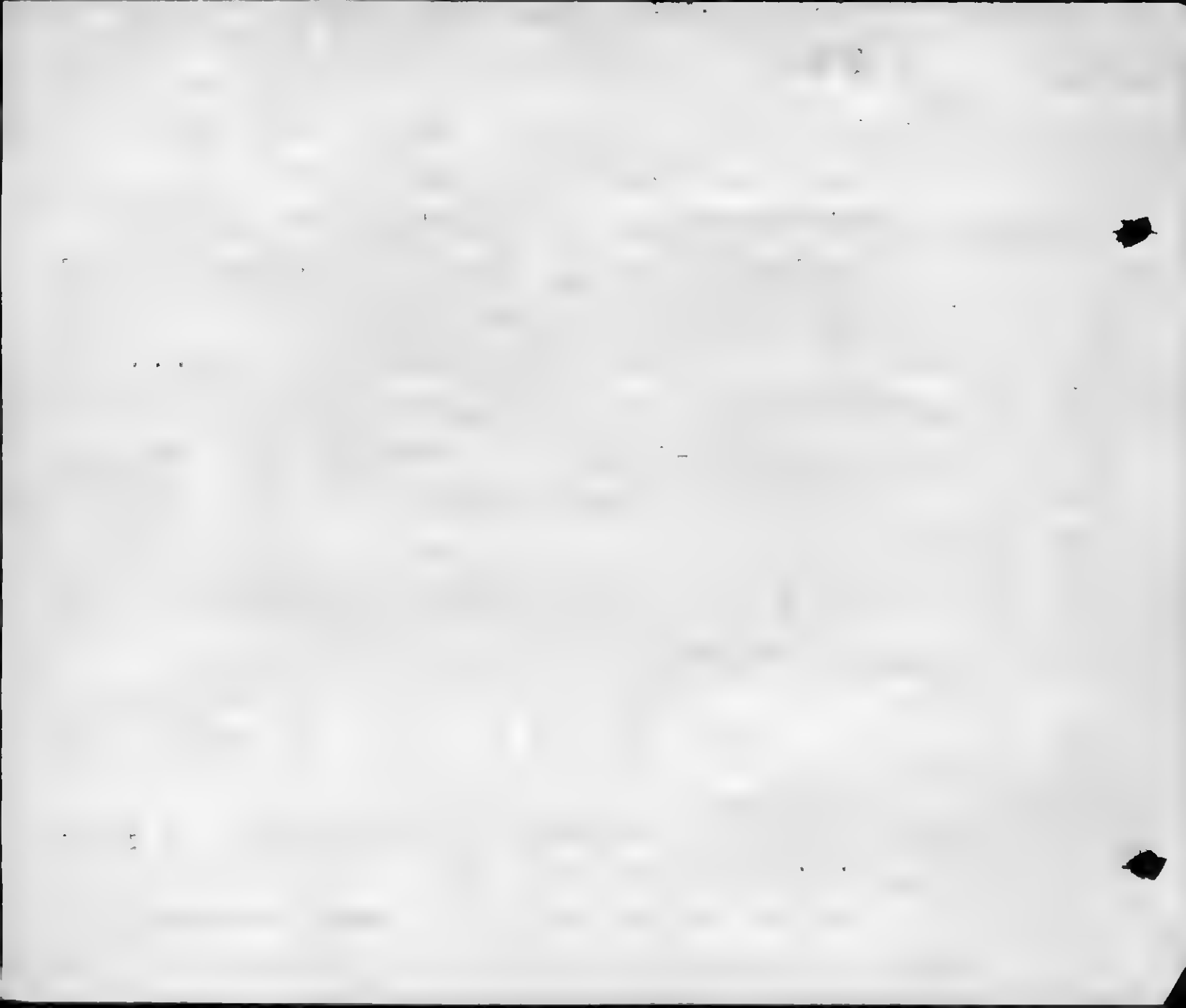
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60450

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>	
c. LENGTH OF STAY IN 1b <u>10 years</u>		d. STREET ADDRESS <u>231 E. Baltimore Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>231 E. Baltimore Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles</u> <u>Thomas</u> <u>Humbert</u>		4. DATE OF DEATH Month Day Year <u>January</u> <u>1</u> <u>19 61</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH Month Day Year <u>March 27, 1910</u> <u>50</u> yrs.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years if under 1 year, if under 24 hrs.) Months Days Hours Min. <u>50</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Humbert</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Boyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-3190</u>	
17. INFORMANT <u>Miss Nellie Humbert, Taneytown, Maryland</u>		Address <u>Miss Nellie Humbert, Taneytown, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Occlusion</u> 420.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. S. McVaugh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. McVaugh</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Acting</u>		DATE SIGNED <u>1/3/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR <u>G.O. Fuss & Son</u>		24a. REC'D BY REGISTRAR <u>John H. Skiles</u>	
ADDRESS <u>Taneytown, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	
DATE <u>JAN 5 '61</u>			



453

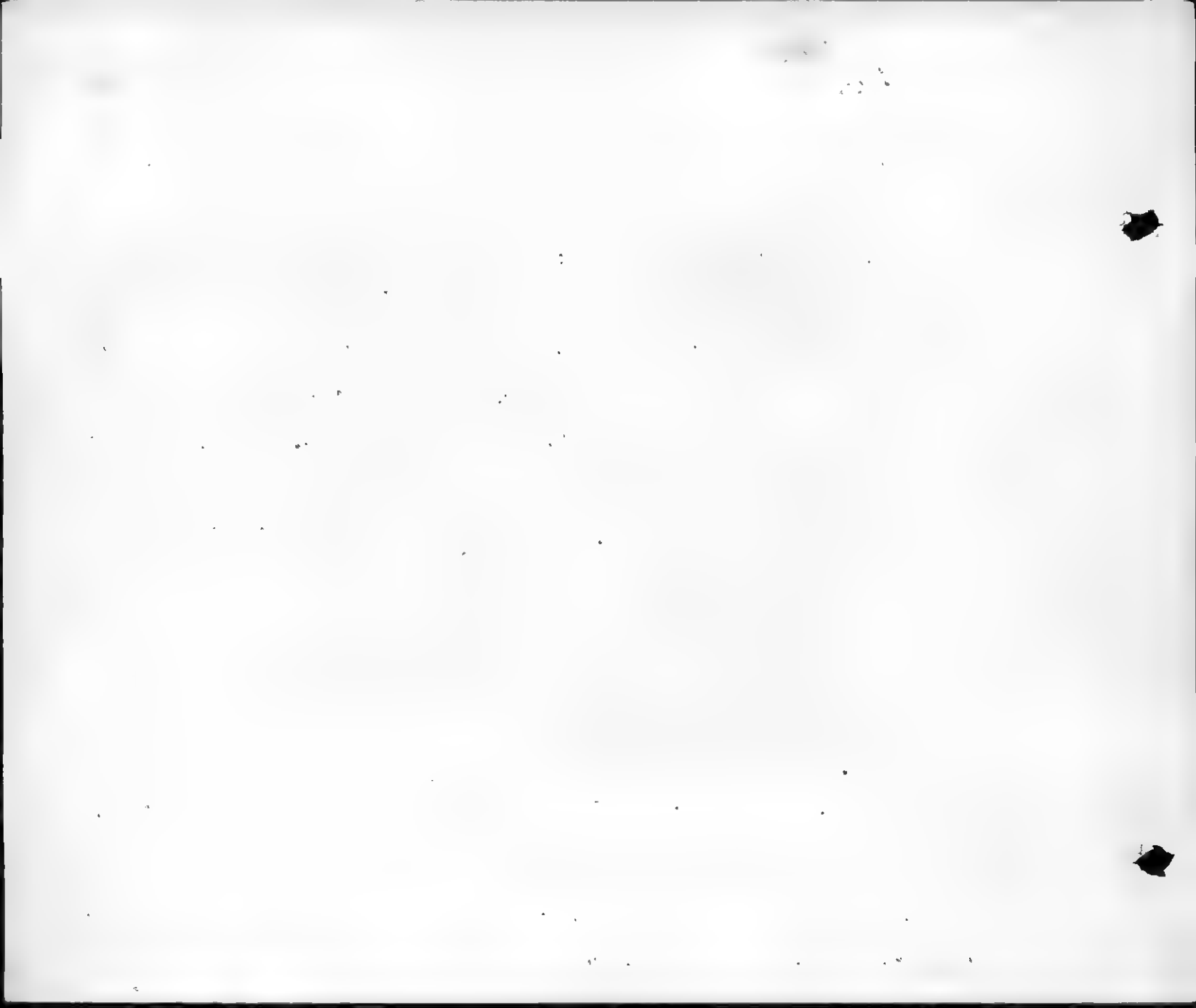
CERTIFICATE OF DEATH

Reg. Dist. No. 00451

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT ARCHIBALD KEEFER</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 15 - 1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN KEEFER</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA FOWLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-38-9862A</u>	
17. INFORMANT <u>BERTIE KEEFER</u>		Address <u>RURAL NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>1624</u> IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>(Rt Lung original site) -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/27/59</u> , 19 <u> </u> , to <u>11/9/61</u> , 19 <u> </u> , that I last saw the deceased alive on <u>11/8/61</u> , 19 <u> </u> , and that death occurred at <u>2:15</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.		ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>11/9/61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/12/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST JAMES</u>	22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hatcher Jones</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 11 '61</u>	
ADDRESS <u>New Windsor, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

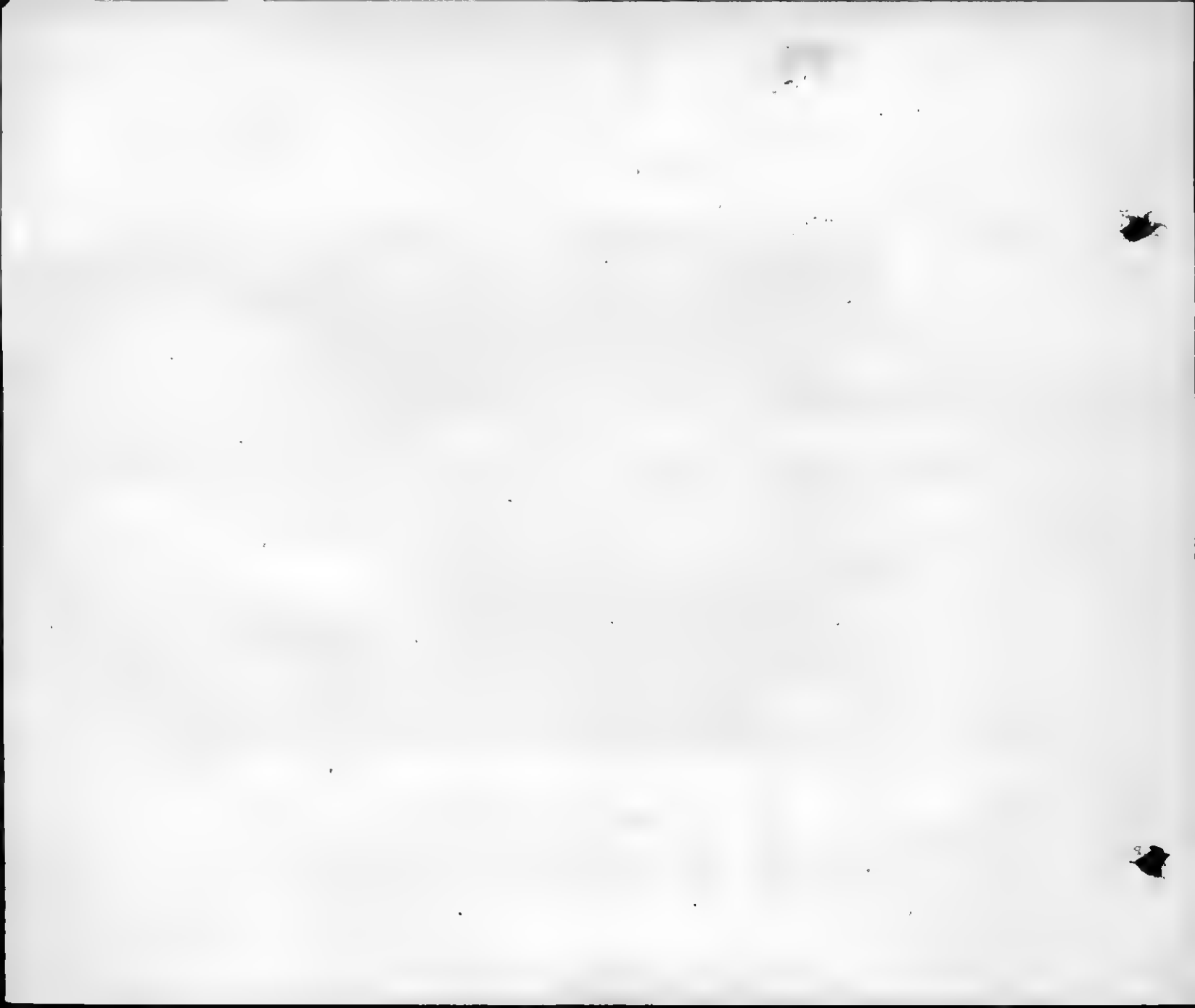
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

454

60452

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 mos.-13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Orville Middle Henry Last KEFAUVER				4. DATE OF DEATH Month 1 Day 28 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-81	9. AGE (In years last birthday) 79 yrs	IF UNDER 1 YEAR Months Days Hours Min	F UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, laborer			10b. KIND OF BUSINESS OR INDUSTRY f arm		11. BIRTHPLACE (State or foreign country) Maryland		12. CIT ZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Oliver Kefauver				14. MOTHER'S MAIDEN NAME Martha Nikirk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis.							days
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) Arteriosclerotic cardio-vascular disease.							years
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
C.B.S. assoc. with cerebral arteriosclerosis, with psy. reaction?							
C.B.S. assoc. with senile brain disease, with psychotic reaction?							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-14 1961 to 1-28 1961 , that (I) (we) last saw the deceased alive on 1-28-1961 , and that death occurred at 8:42 a.m. , from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladde, M.D.				22b. DATE SIGNED 1-28-61			
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladde, M.D.				22d. ADDRESS Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		1/31/1961		Reform Dem.		Middletown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gladde, J. R.				25a. REC'D BY REGISTRAR JAN 31 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION



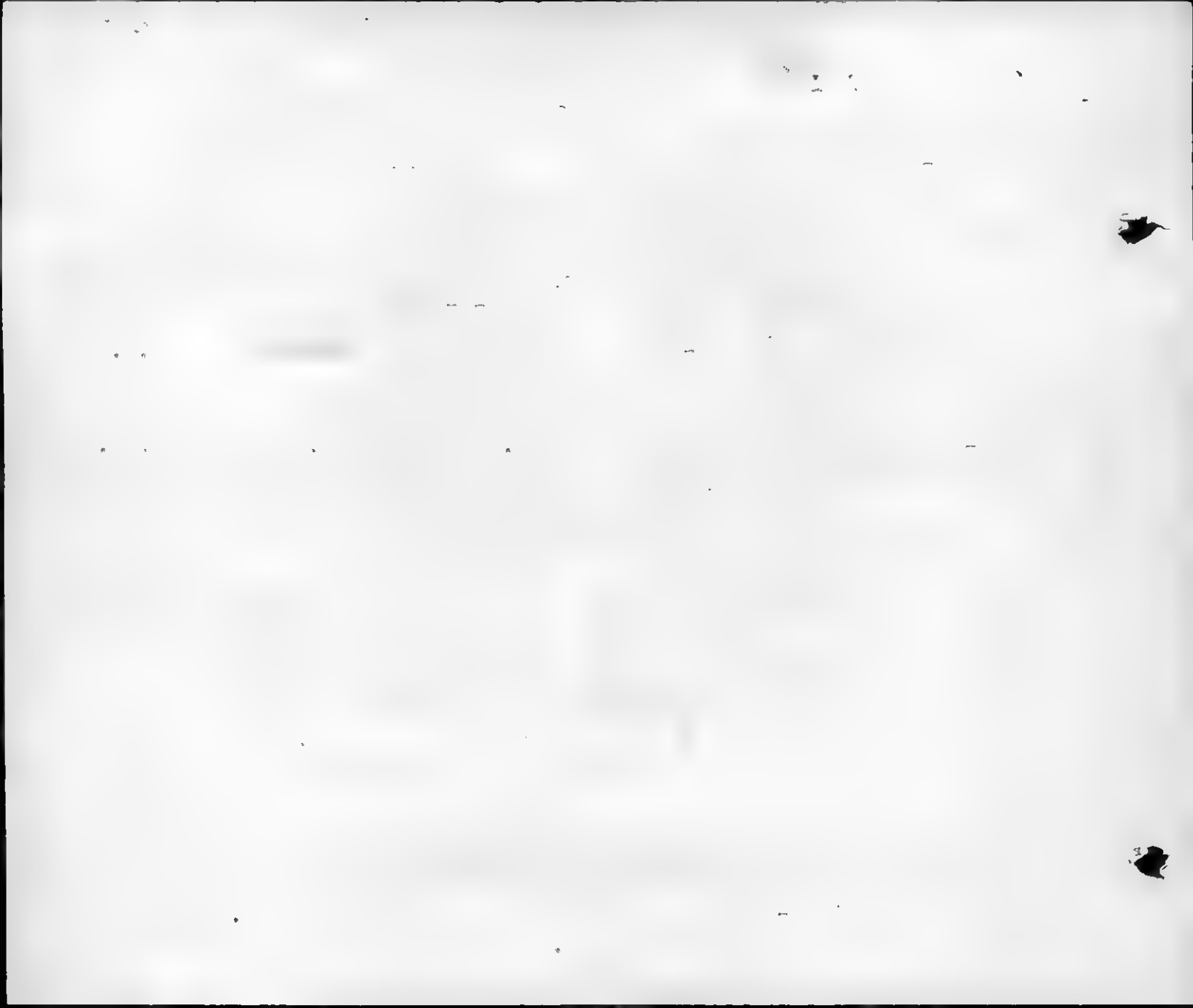
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15:14
ISM 9/59

1
455
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60453

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville			
				d. STREET ADDRESS Johnsville			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE ANTHONY KING				4. DATE OF DEATH Month Day Year JANUARY 24, 1961			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-1960	
9. AGE (In years last birthday) 2		10. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Maryland Carroll Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Adeline Ison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Mrs. Adeline King, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 710			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-12 19 60 , to JAN 24 19 61 , that (I) (we) last saw the deceased alive on 11-24 19 60 , and that death occurred at 6:45 P.M. Me causes and on the date stated above.							
22a. SIGNATURE N. Q. Hester				22b. DATE JAN-25-1961			
22c. PHYSICIAN'S NAME (Type) Dr. C. S. T. N. E.				22d. ADDRESS 121 E. 9th St. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-26-1961		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town, or county) (State) Carroll CO., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				25. REC'D BY REGISTRAR DATE JAN 27 '61			
ADDRESS Winfield, Md.				25b. REGISTRAR'S SIGNATURE C. M. Waltz			



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 456
 CERTIFICATE OF DEATH

60454

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 9 days				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Finksburg R.1 d. STREET ADDRESS 1 - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Raymond Lambert				4. DATE OF DEATH Month Day Year January 25 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-82	
9. AGE (In years last birthday) 78 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer <i>Wm. Strick</i>		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Lambert		14. MOTHER'S MAIDEN NAME Emily		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown -	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Arteriosclerosis DUE TO (c) Terminal Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH years years 3 or 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. - - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (this hospital) attended the deceased from 1-16- to 1-25- 1961 , that (I) (we) last saw the deceased alive on 1-25- 1961 , and that death occurred at 3:40 AM, from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladue				22b. DATE SIGNED 1-25-61			
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.				22d. ADDRESS Springfield State Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL. (Specify) Burial		23b. DATE THEREOF 1/28/61		23c. NAME OF CEMETERY OR CREMATORY Winters Cemetery		23d. LOCATION (City, town, or county) (State) Rural New Windsor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. C. Myers, Jr. Westminster, Md.				25a. REC'D BY REGISTRAR JAN 27 '61		25b. REGISTRAR'S SIGNATURE Charles S. Hume	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00455

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Gist		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gist--P. O. Sykesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R. D. Sykesville		d. STREET ADDRESS R. D. 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle O. Last LINDSAY		4. DATE OF DEATH Month January Day 12 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1893
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Lindsay		14. MOTHER'S MAIDEN NAME Irene Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-9324	
17. INFORMANT Mr. LeRoy Lindsay, Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1961	
22c. NAME OF CEMETERY OR LABORATORY Harmony Grove		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		24a. REC'D BY REGISTRAR DATE JAN 16 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



458

CERTIFICATE OF DEATH

Reg. Dist. No.

00456

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>1-yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>174 William St</u>				d. STREET ADDRESS <u>174 William St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE - V - LOATS</u>				4. DATE OF DEATH Month Day Year <u>Jan 6 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 1 - 1876</u>	
9. AGE (In years last birthday) <u>85 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Hively</u>				14. MOTHER'S MAIDEN NAME <u>Mary Britton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>160-16-12648</u>			
17. INFORMANT <u>Margaret L Price Westminster Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO <u>Cerebrovascular accident & paralysis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 year</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 10, 1960</u> to <u>Jan 6, 1961</u> that I last saw the deceased alive on <u>Jan 6, 1961</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Julius Chapko</u>				ADDRESS (Street, city or town, state) <u>854 W Dun St Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>Julius Chapko</u>				DATE SIGNED <u>1/7/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1-9-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenhastes</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll as Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin A. Gorton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Jan 10 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



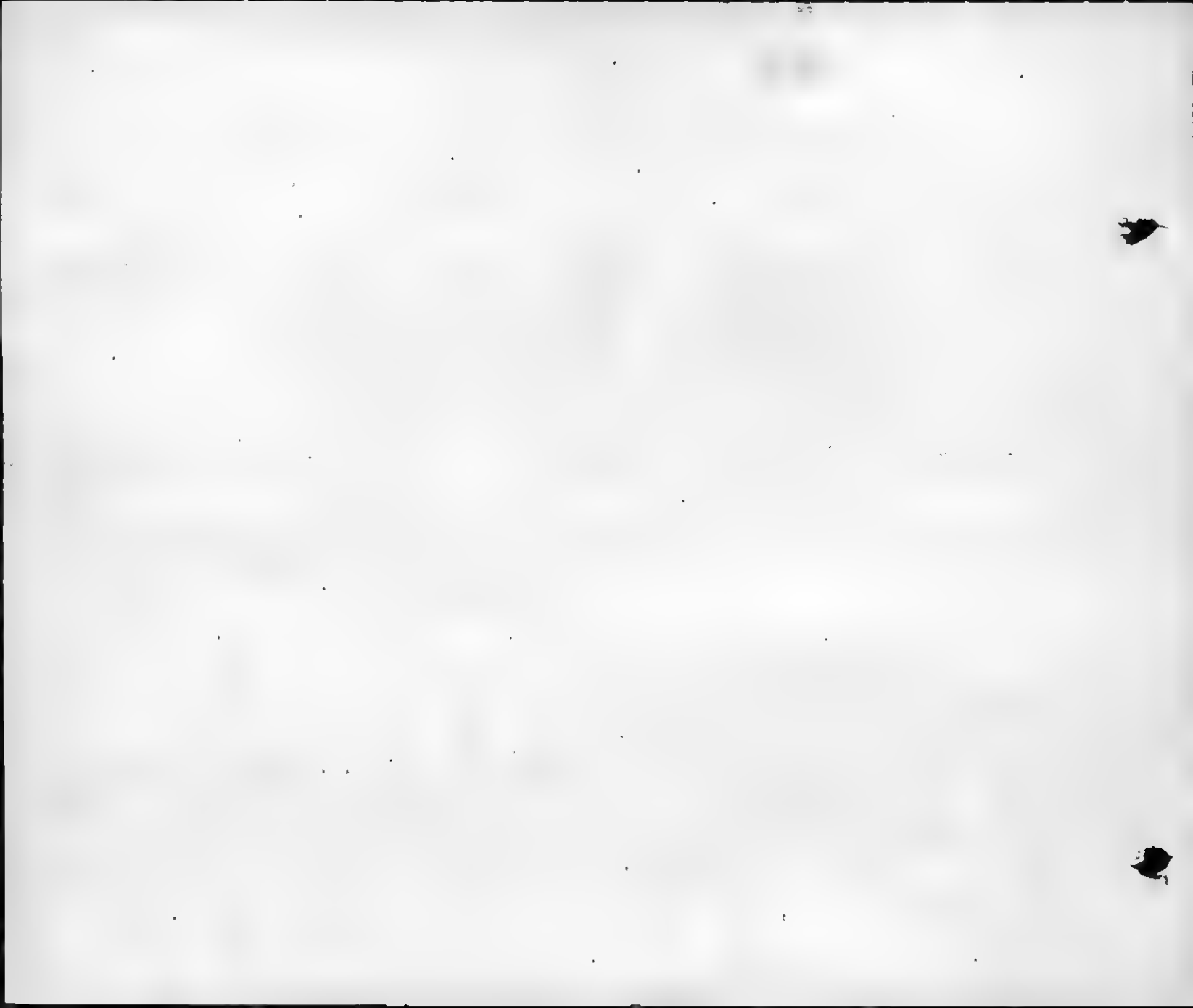
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66457

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 2 mos.-12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore #18 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #18 d. STREET ADDRESS 1528 Homestead St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Frank LOWERY		4. DATE OF DEATH Month Day Year 1 - 27, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-79
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Builder		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Lowery		14. MOTHER'S MAIDEN NAME Alice Covington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with congestive failure. DUE TO (c) Generalized arteriosclerosis marked. years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-15-60 to 1-27-61 , 19____ that (I) (we) last saw the deceased alive on 1-27- 19 61 , and that death occurred at 4:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 1-27-61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 31, 1961	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 2 '61	
25b. REGISTRAR'S SIGNATURE Lucy S. Frank			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

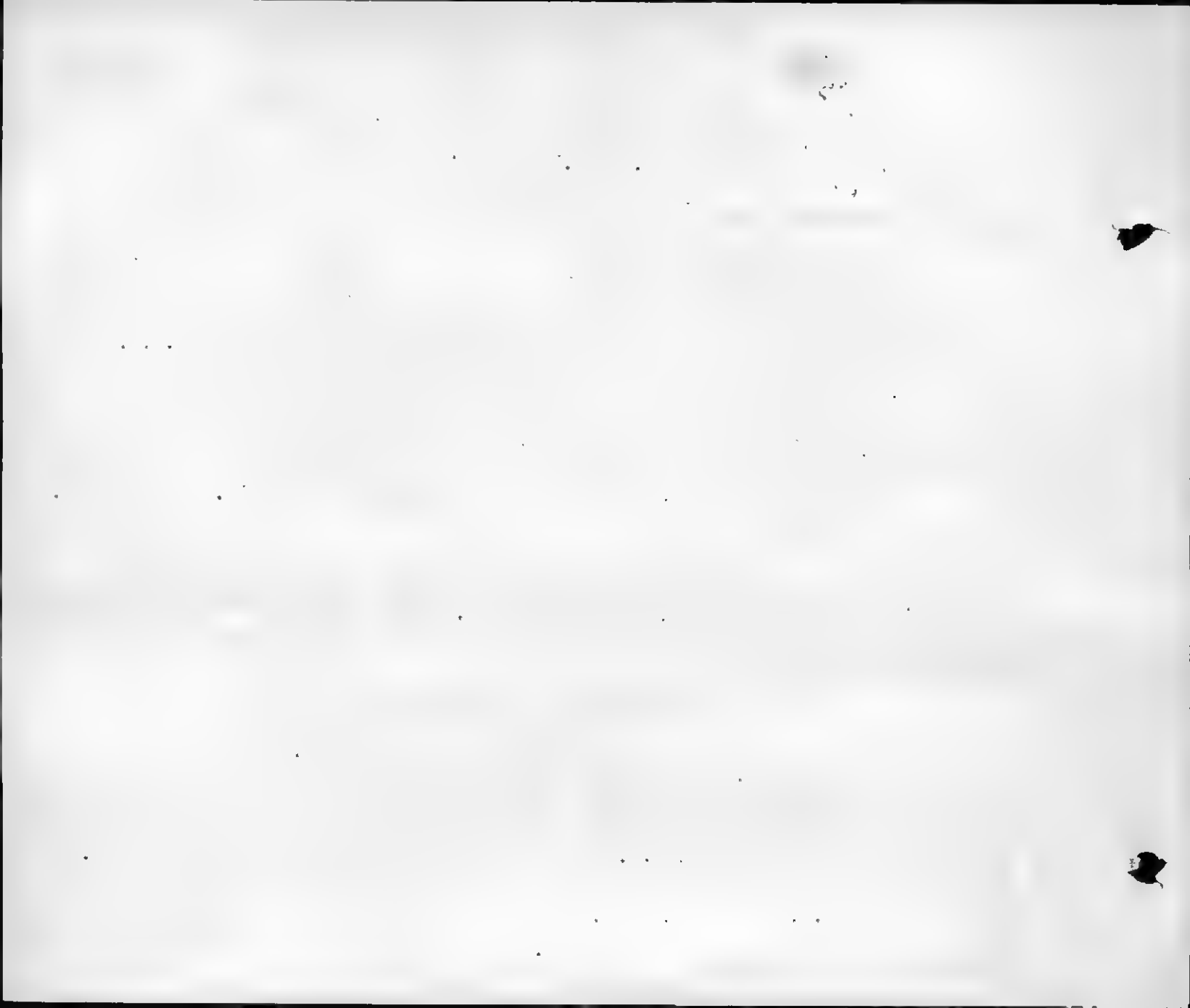
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

460

00458

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 25yrs. 10mos. 18days Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS -			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Harry Elmer Lucas				4. DATE OF DEATH Month Day Year January 5, 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1891	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Lucas				14. MOTHER'S MAIDEN NAME Susie Rein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of rectum with metastasis to brain. 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, other and unspecified.						INTERVAL BETWEEN ONSET AND DEATH Months.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/7/55 19 to Jan. 5, 1961, that (I) (we) last saw the deceased alive on Jan. 5, 1961 and that death occurred at 2:18PM from the causes and on the date stated above							
22a. SIGNATURE <i>Agustín del Campo</i> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/5/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 8, 1961		23c. NAME OF CEMETERY OR CREMATORY E. U. B. Cemetery		23d. LOCATION (City, town, or county) (State) Shenandoah, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Werner & Haight Funeral Home, Sykesville, Md.</i> <i>Werner & Haight</i>				25a. REC'D BY REGISTRAR JAN 9 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. [illegible]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

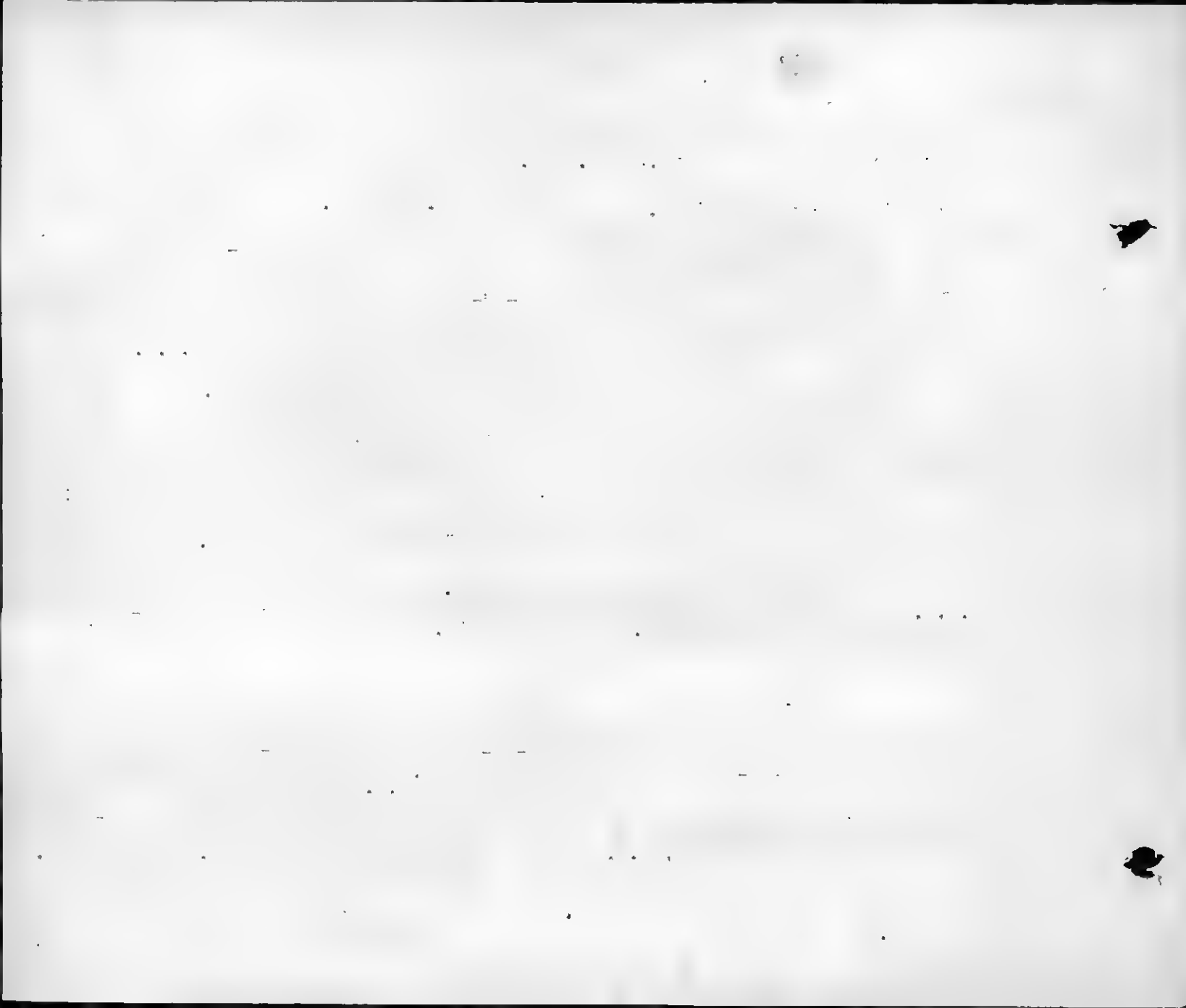
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66459

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7yrs. 2mths. 7dys.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Martell				4. DATE OF DEATH Month 1- Day 15 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-28-1880	
9. AGE (in years last birthday) 80 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Martell				14. MOTHER'S MAIDEN NAME Maggie Barber.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO (If yes, give year or dates of service) 712-05-5065		17. INFORMANT Address Hospital records Sykesville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive & arteriosclerotic heart disease. DUE TO (c) Carcinoma, sigmoid colon. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) C.B.S. associated with circulatory disturbances with cerebral arteriosclerosis with psychotic reaction. Bronchopneumonia.							INTERVAL BETWEEN ONSET AND DEATH 1 week Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-20-1960 to 1-15-1961 , that (I) (we) last saw the deceased alive on 1-15-1961 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo. M.D.				22b. DATE SIGNED 1-15-1961		22c. PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.	
22d. ADDRESS Springfield State Hospital. Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Jan. 19 1961		23c. NAME OF CEMETERY OR CREMATORY Walden Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore - Md	
24. FUNERAL DIRECTOR'S SIGNATURE Carl W. Anderson, Funeral Home, Inc.				25a. REC'D BY REGISTRAR JAN 20 1961		25b. REGISTRAR'S SIGNATURE C. Thur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 9/59

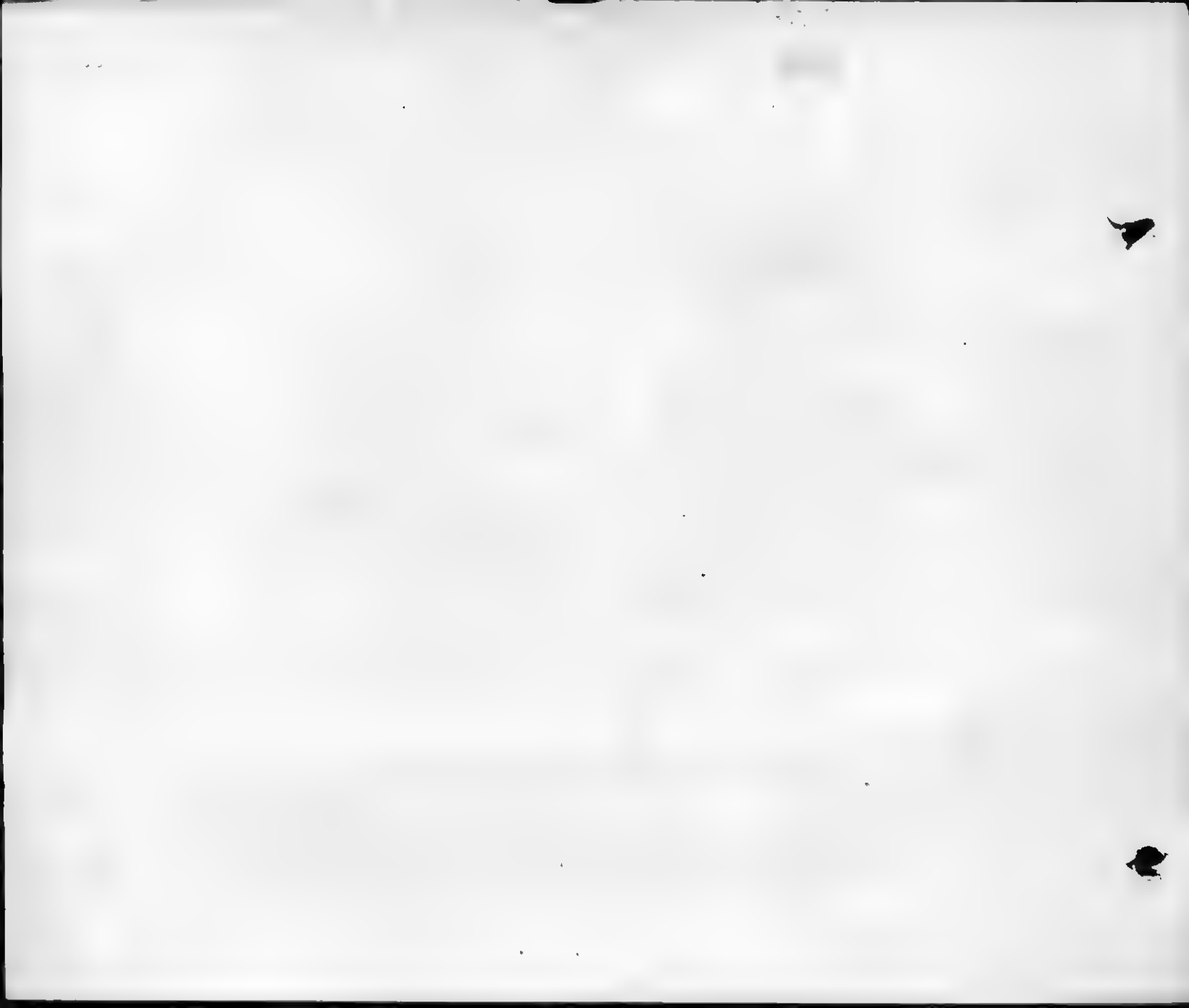
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

462

CERTIFICATE OF DEATH

C0460

1 PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
3 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>22-Y 7 M 12 D</i>	
4 d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Springfield State Hosp</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md</i>	
5 f. STREET ADDRESS <i>? Winchester St</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Glady's</i> First Middle Last <i>MAYO</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>19</i> Year <i>1961</i>	
5. SEX <i>F.</i>	6 COLOR OR RACE <i>W</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <i>11-14-99</i>
9. AGE (in years last birthday) <i>61</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11 BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Stewart Webster</i>		14. MOTHER'S MAIDEN NAME <i>Alphine Thomas</i>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16 SOCIAL SECURITY NO. <i>?</i>	
17 INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatous Metastases</i> <i>164X</i> DUE TO <i>To the vital organs of the body,</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchopneumonia</i> DUE TO (c) <i>Metastatic Ca. of Mediastinum Spine & Adrenals</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Schizophrenic reaction, paranoid type</i>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (if (this hospital) attended the deceased from <i>6-2-38</i> to <i>1-14-1961</i> , that (if (we) last saw the deceased alive on <i>1-14-1961</i> , and that death occurred at <i>1240 A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Konstantin Weber</i> M.D.		22b. DATE SIGNED <i>1-14-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Konstantin WEBER M.D.</i>		22d. ADDRESS <i>Oak Street, Sykesville, Maryland</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>1/17/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE NATIONAL CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i>
24 FUNERAL DIRECTOR'S SIGNATURE <i>HENRY SANDER & SONS INC. BALTO. MD.</i>		25a. REC'D BY REGISTRAR <i>JAN 18 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>

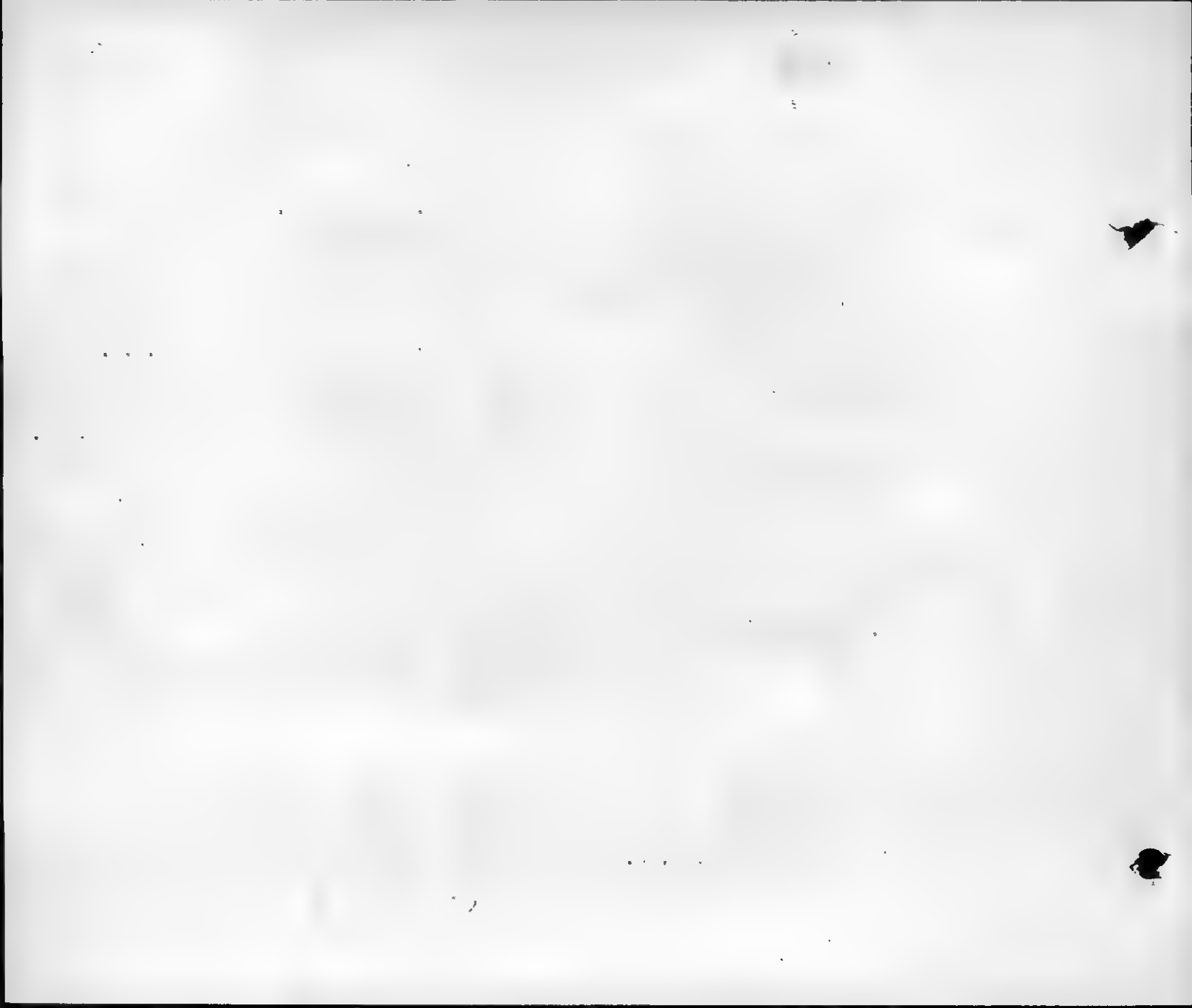


1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

463

00461

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville				c. LENGTH OF STAY IN 1b 17 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2625 N. Calvert St.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Cecilia Last McElheney				4. DATE OF DEATH Month 1 Day 9 Year 1961			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/25/87	
9. AGE (In years last birthday) 73 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Philip McElheney		14. MOTHER'S MAIDEN NAME Mary Ellen Ford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Springfield State Hospital records Address Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Coronary arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Days Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/12 1959 to 1/9/ 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/9/ 1961 , and that death occurred at 8:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Konstantin Weber</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-12-61		23c. NAME OF CEMETERY OR CREMATORY ANNUNCIATION GEN.		23d. LOCATION (City, town, or county) (State) McSherrystown ADMIN PA.	
24a. FUNERAL DIRECTOR'S SIGNATURE <i>Harry J. Walter</i>				ADDRESS McSherrystown Pa.		25a. REC'D BY REGISTRAR DATE JAN 25 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Finner</i>			

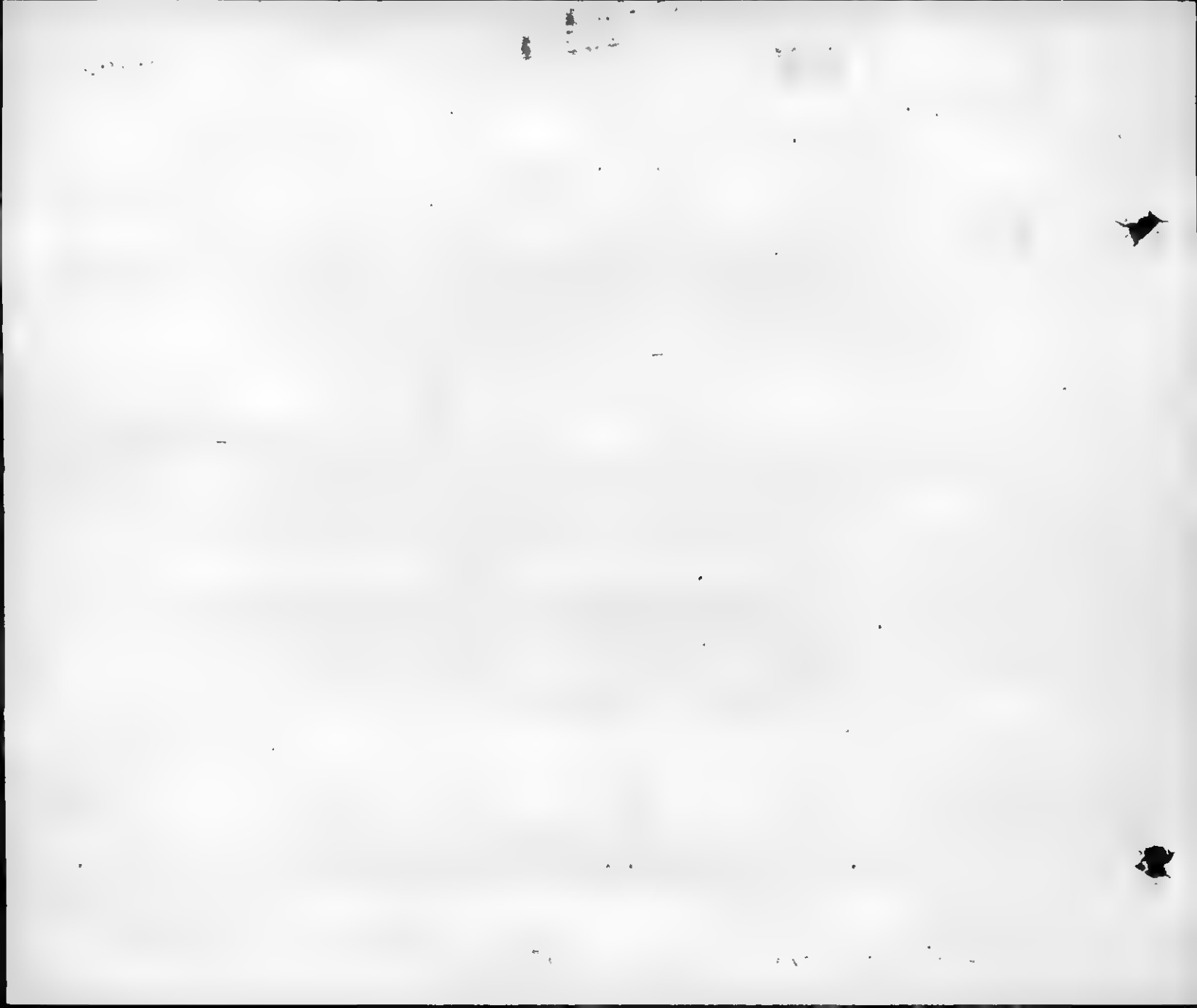


CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

464

60462

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b Byrs. 5 mos. 26 das			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 1804 Guilford Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Elizabeth Middle Mullea Last Morton		4. DATE OF DEATH		Month January Day 31 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-15-69	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? unknown				13. FATHER'S NAME Peter Mullea			
14. MOTHER'S MAIDEN NAME Barbara Ommart				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO -				17. INFORMANT Springfield State Hospital - Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Peripheral vascular insufficiency with gangrene						INTERVAL BETWEEN ONSET AND DEATH 1 week years months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. - - 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (this hospital) attended the deceased from 8-5-1961 to 1-31-1961 , that (I) (we) last saw the deceased alive on 1-31-1961 and that death occurred at 1:35 P.M. from the causes and on the date stated above							
22a. SIGNATURE J. Raymond Gladue, M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/31/61	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Feb 3, 1961		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Henderson, North Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Jones Co., 2901-1448 1/2 W.				25a. REG'D BY REG-STRAR FEB 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Jones	



may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

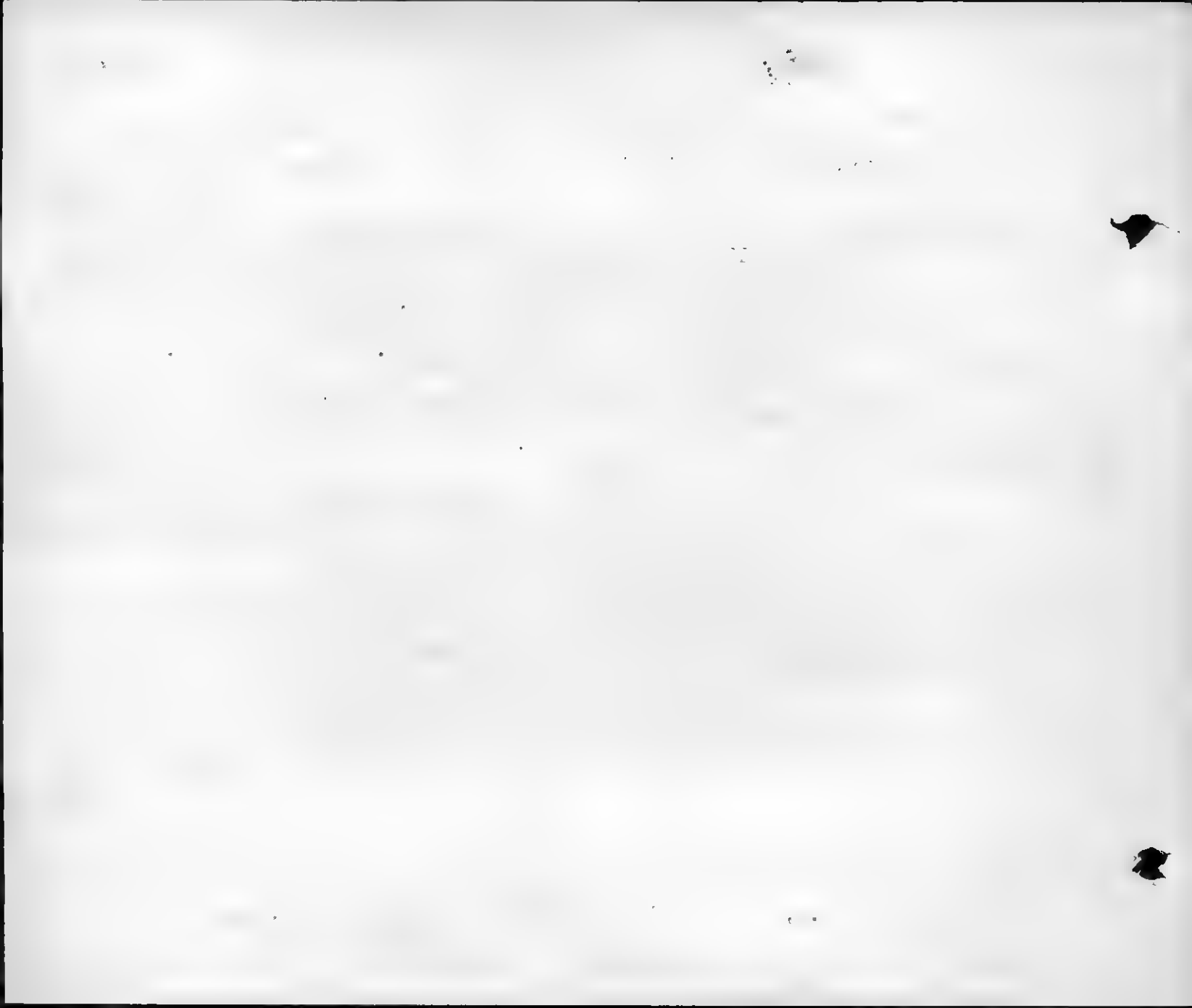
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465

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66463

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle Last <u>Myers</u>				4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 13, 1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lewis Myers</u>				14. MOTHER'S MAIDEN NAME <u>Missouri Nusbaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mrs. Marshall Myers, R#5 Westminster, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 18, 1960</u> to <u>Jan 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 6, 1960</u> , and that death occurred at <u>7AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>J. H. Legg</u>				22b. DATE SIGNED <u>Jan 1, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. H. LEGG</u>				22d. ADDRESS <u>Uniontown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 4, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Uniontown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Fuss & Son</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Finney</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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466
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00464

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, c. LENGTH OF STAY IN lb 42y 8m 3d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Unknown b. COUNTY Unknown c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Abraham Middle - Last Paymer			4. DATE OF DEATH Month 1 Day 17 Year 19 61												
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-1887		9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 73		11. IF UNDER 24 HRS. Days 73		12. CITIZEN OF WHAT COUNTRY? Germany	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory work				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? Germany			
13. FATHER'S NAME Meyer Paymer				14. MOTHER'S MAIDEN NAME Annie Hirsch				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown							
16. SOCIAL SECURITY NO. none				17. INFORMANT Hospital Records Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiac insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) 5 yrs. plus												INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1 1953 to Jan 16 1961 , that (I) (we) last saw the deceased alive on Jan 17 1961 , and that death occurred at 9:20 AM , from the causes and on the date stated above.															
22a. SIGNATURE Myron Nizankowsky M.D.												22b. DATE SIGNED 1-17-61			
22c. PHYSICIAN'S NAME (Type) Myron Nizankowsky, M.D.												22d. ADDRESS Springfield State Hospital			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL				23b. DATE THEREOF Jan 18/61				23c. NAME OF CEMETERY OR CREMATORY Oheb Shalom				23d. LOCATION (City, town, or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON ADDRESS 4000 Bees, Inc. BALTO. 15, MD.								25a. REC'D BY REGISTRAR JAN 19 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



467

CERTIFICATE OF DEATH

Reg. Dist. No.

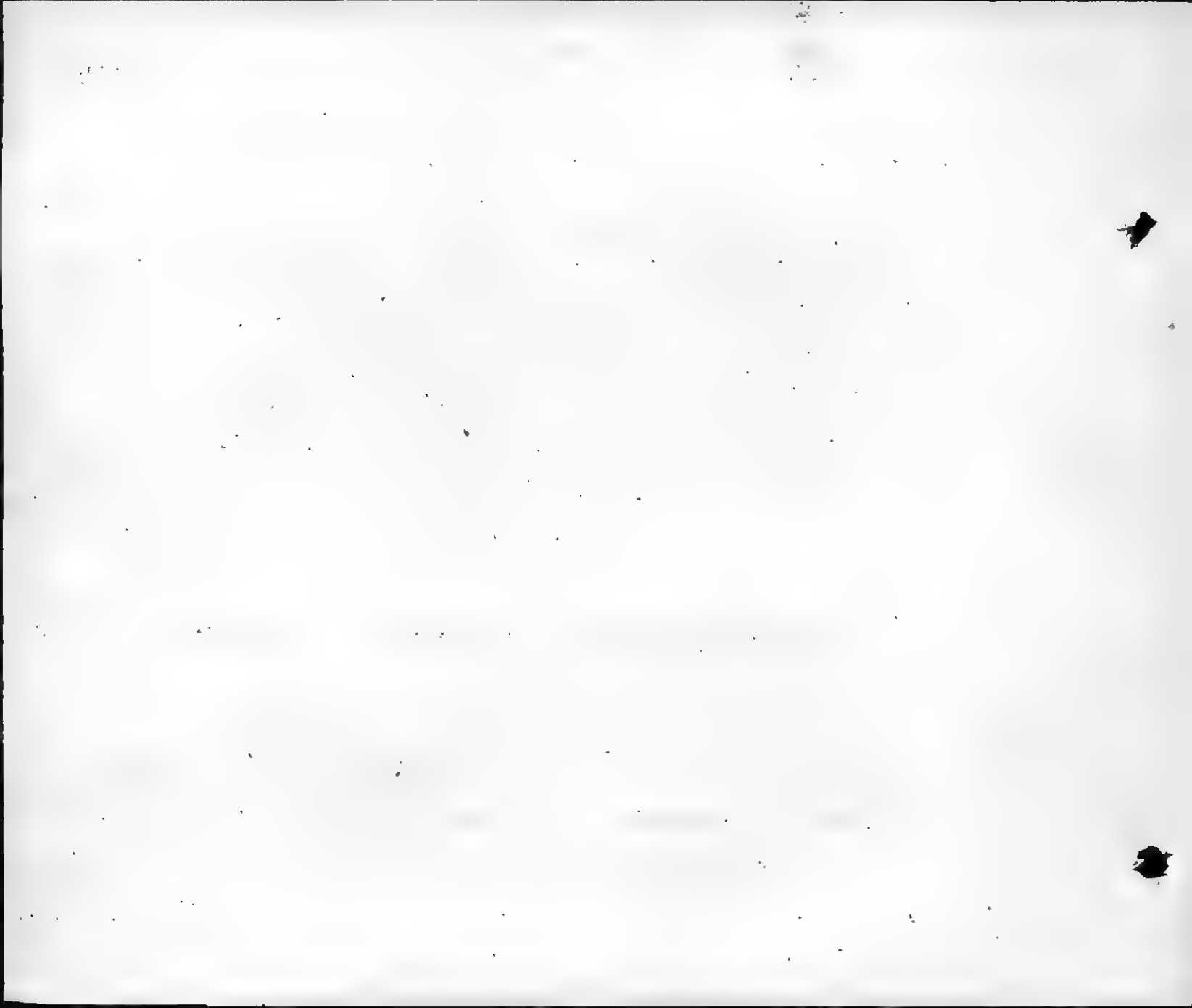
00465

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN lb <u>16 yrs 2</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>61 Carroll St</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>61 Carroll St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>REBECCA</u> Last <u>PETRY</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1882</u>
9. AGE (In years last birthday) <u>78</u>		10. IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	11. IF UNDER 24 HRS Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Amos Fitze</u>	
14. MOTHER'S MAIDEN NAME <u>Rebecca Ann Petry</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Miss Rebecca Ann Petry, same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral Gastro-enteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Virus infection</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myelogenous Leukemia; Hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 15, 1950</u> to <u>Jan 28, 1961</u> , that I last saw the deceased alive on <u>Jan 28, 1961</u> , and that death occurred at <u>8:02 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Julius Chepko</u>		M.D. <u>851 W. Green St</u>	
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>		DATE SIGNED <u>1/29/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/31/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Branch Rural Cemetery, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 1 '61</u>		DATE <u>—</u>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

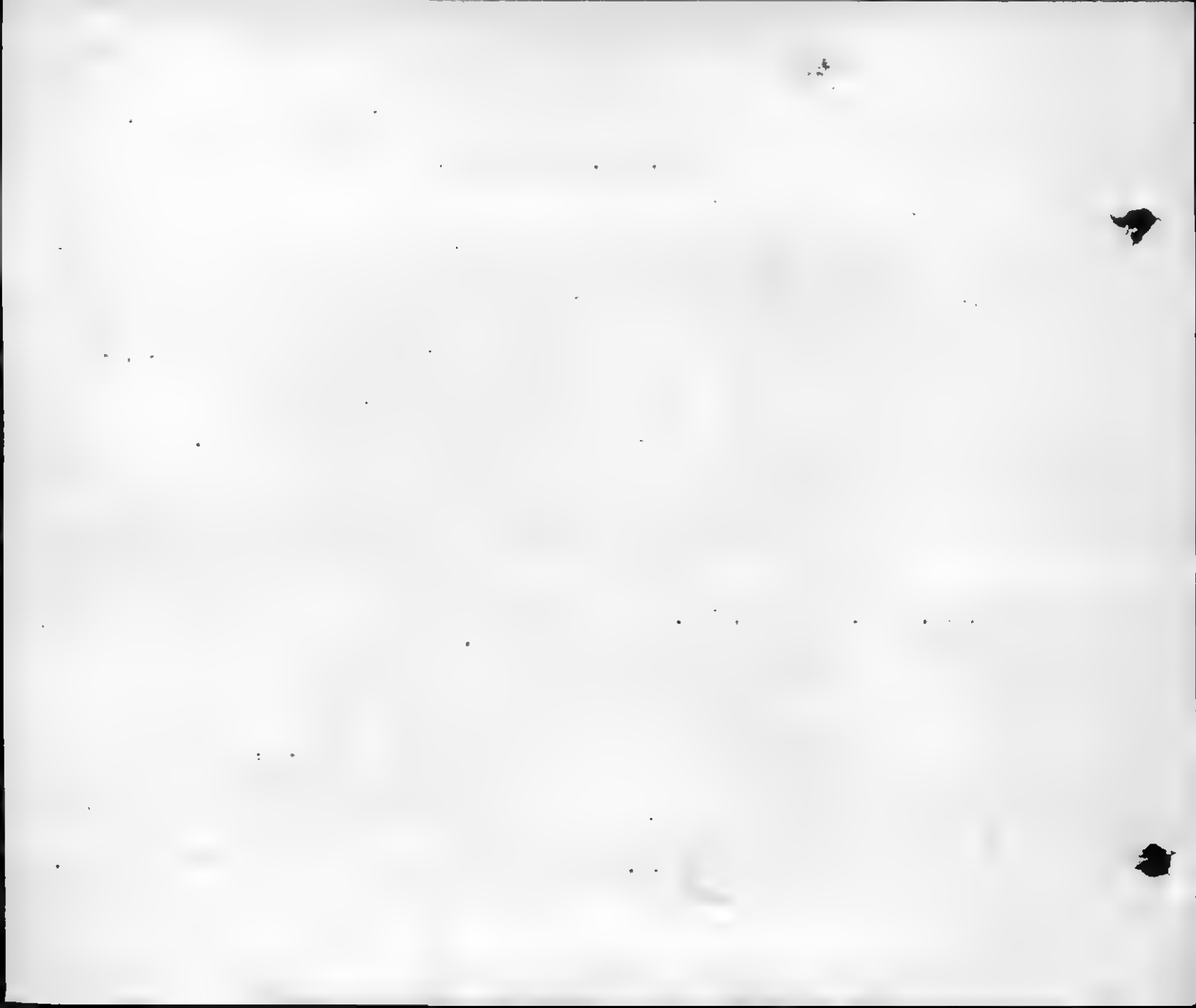
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
468
CERTIFICATE OF DEATH
60466

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5yrs. 9mos. 21days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Millard Middle Alonzo Last Reid				4. DATE OF DEATH Month January Day 7 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 13, 1879	
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 81 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Kansas				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Reid				14. MOTHER'S MAIDEN NAME Lottie Kurns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -			
17. INFORMANT Springfield Hospital Records.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) - DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis without qualifying phrase, plus late latent syphilis.							19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) Springfield			(County) Montgomery		(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from 3/16/55 19 65 to Jan. 7 19 61 that (I) (we) last saw the deceased alive on 1/7/61 19 61 and that death occurred at 9:30PM on the causes and on the date stated above							
22a. SIGNATURE Agustin del Campo				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/8/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>		23b. DATE THEREOF 1-12-61		23c. NAME OF CEMETERY OR CREMATORIUM V. Ind. Med. School		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell				ADDRESS 1234 S. 8.		25a. REC'D BY REGISTRAR DATE JAN 20 1961	
25b. REGISTRAR'S SIGNATURE Conrad A.							

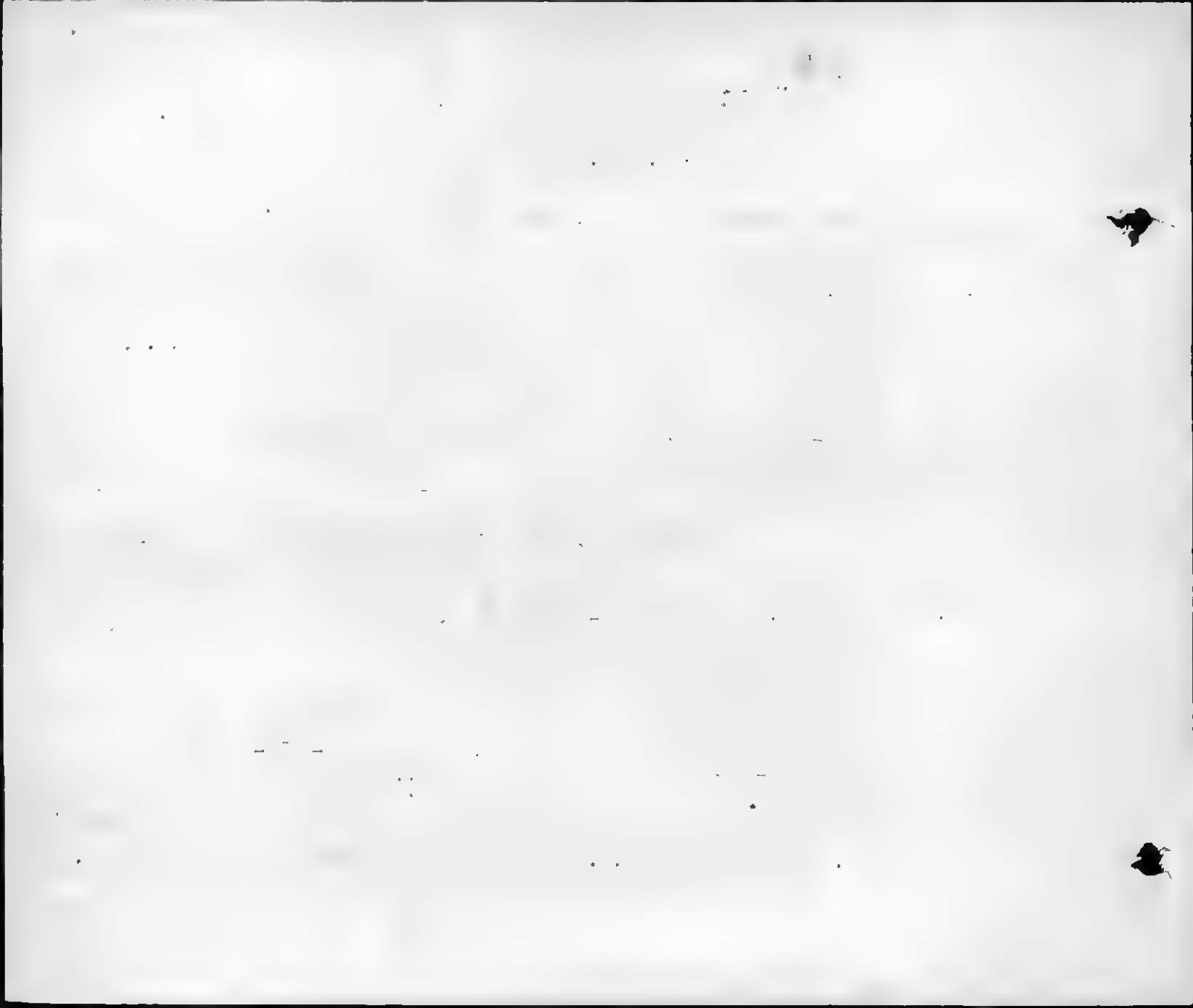


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

469

60467

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 9yrs. 8mos. 10days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 5100 Walther Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Winifred Middle Elizabeth Last Root				4. DATE OF DEATH Month January Day 15 , Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1896		9. AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McMahon				14. MOTHER'S MAIDEN NAME Mamie Strasburg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-3600		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with syphilitic meningo-encephalitis.						INTERVAL BETWEEN ONSET AND DEATH 1 week Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1961 , to 1-15-1961 , that (I) (we) last saw the deceased alive on 1-15-1961 , and that death occurred at 11:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladue M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/15/61	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-19-1961		23c. NAME OF CEMETERY OR CREMATORY McCreland Park		23d. LOCATION (City, town, or county) (State) BALTO MD	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kopp ADDRESS 1305 Highland St				25a. REC'D BY REGISTRAR DATE JAN 19 '61		25b. REGISTRAR'S SIGNATURE Christina S. K...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

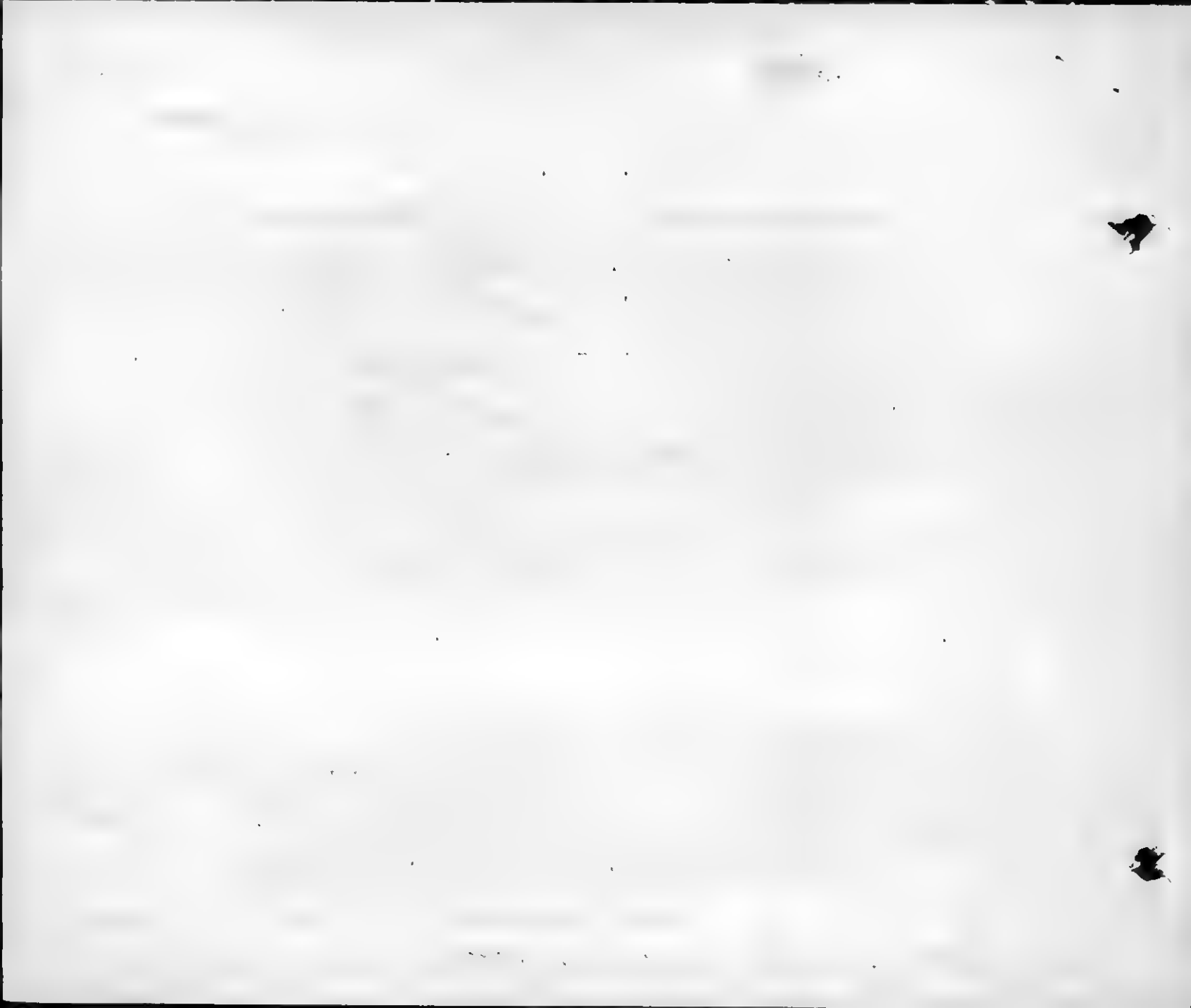
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

470

00468

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY County report			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 27 yrs.-5 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Matteer Middle M. Last SCHNEIDER				4. DATE OF DEATH Month 1 Day 28 Year 1961			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-19-84	
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----			
13. FATHER'S NAME Henry A. Gripp				14. MOTHER'S MAIDEN NAME Isabella Weir			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Silat. Pneumonia 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic congestive heart failure DUE TO (c) Rheumatic heart disease years							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, other and unspecified.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-11 1933 to 1-28 1961 , that (I) (we) last saw the deceased alive on 1-28 1961 , and that death occurred at 7:20 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-28-61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/1/61		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert R. Humphrey				25a. REC'D BY REGISTRAR Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE DATE FEB 2 '61	

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371
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66469

1. PLACE OF DEATH a. COUNTY <u>Danell</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Danell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WILLIAM - L - SHAFFER</u>		4. DATE OF DEATH <u>June 6</u> 19 <u>61</u>	
5. SEX <u>21</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28 - 1916</u>
9. AGE (In years last birthday) <u>45</u> yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Black</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William A. Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>217-108-2845</u>	
17. INFORMANT <u>Charlotte Shaffer - Manchester Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SEX</u> DUE TO <u>Car Pulmonary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Fibrosis</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>24 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 40</u> to <u>1-6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-5</u> 19 <u>61</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M. C. Porterfield</u> M.D.		22b. DATE SIGNED <u>1-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		22d. ADDRESS <u>HAMPSTEAD, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-9-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		23d. LOCATION (City, town, or county) (State) <u>Danell Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar G. Hixton - Hampstead Md</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

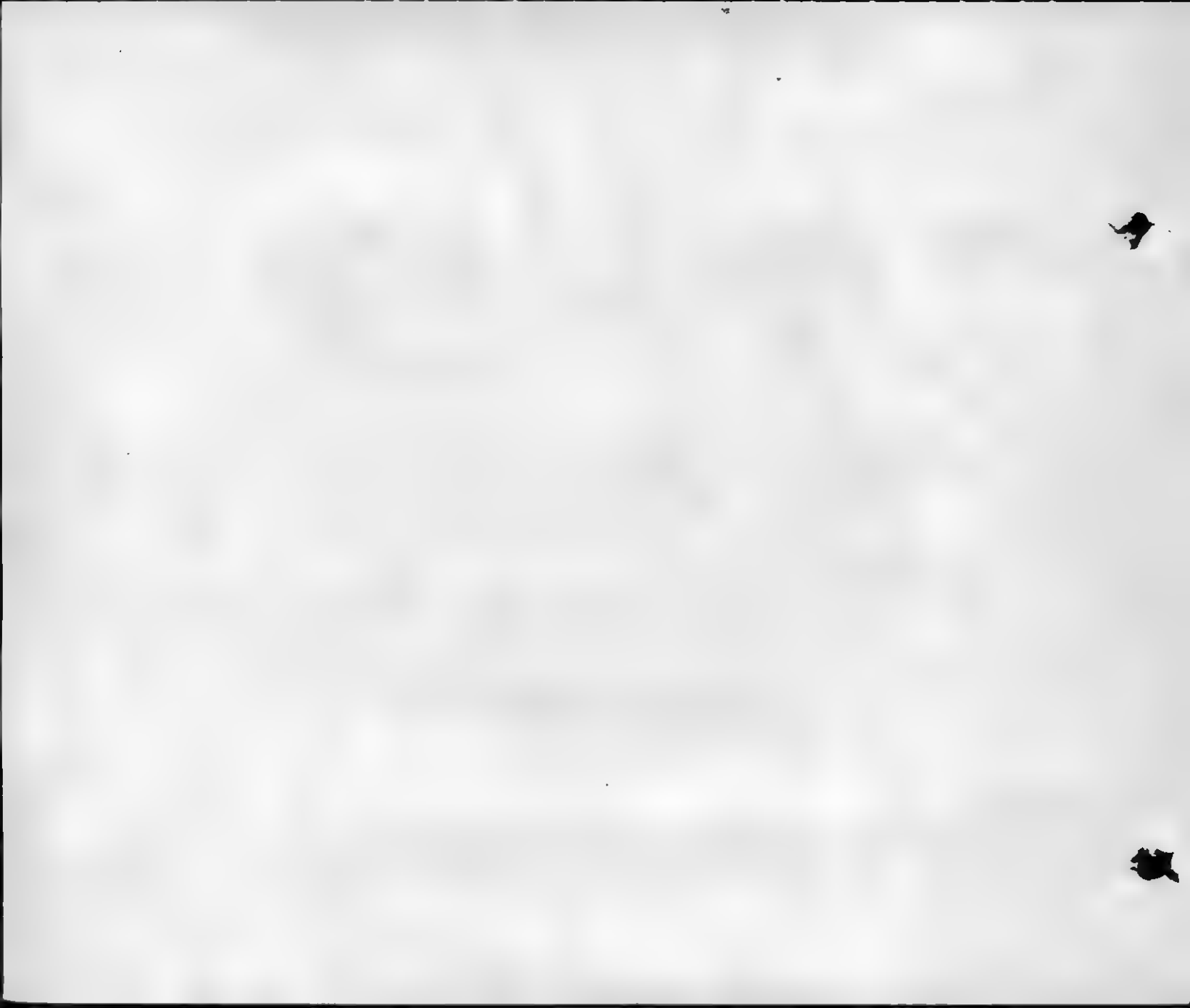
00470

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> c. LENGTH OF STAY IN 1b <u>10 MINUTES</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAIN STREET</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> d. STREET ADDRESS <u>LOCUST ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM GEORGE SKINNER</u>				4. DATE OF DEATH Month Day Year <u>JAN 6 1961</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 6 - 1890</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEMIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT CO.</u>				11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WILLIAM W SKINNER</u>						14. MOTHER'S MAIDEN NAME <u>BETTY MACLEMORE</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>171-05-7794</u>				17. INFORMANT Address <u>REBECCA SKINNER UNION BRIDGE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> </div> </div>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>						DATE SIGNED <u>1/6/61</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1/16/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIT VIEW</u>				22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. H. Hartzler</u>						ADDRESS <u>Union Bridge, Md</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

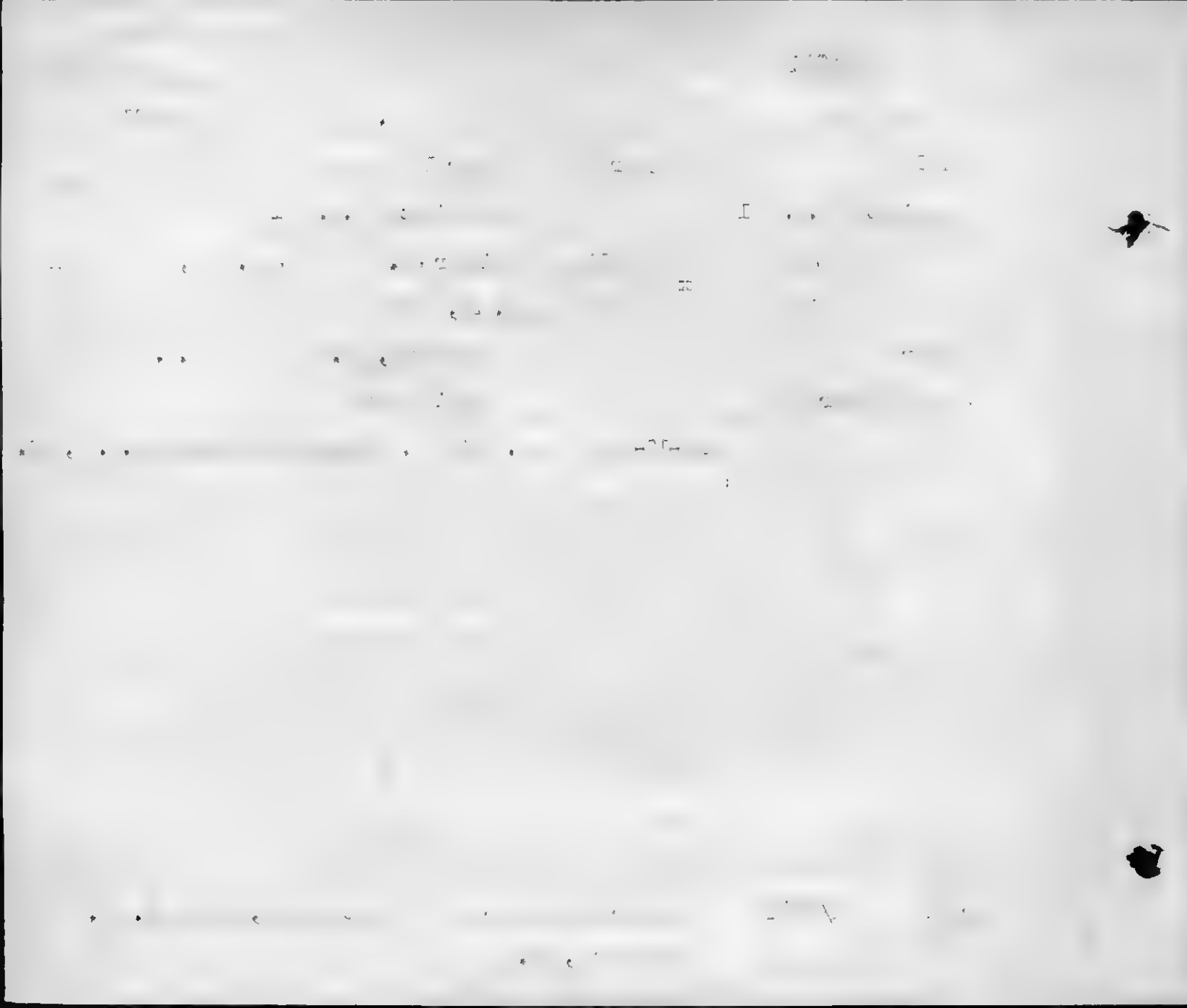
VS. A15ME
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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00471

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Carroll	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 5 Yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Westminster R.D. # 1		d. STREET ADDRESS Westminster R.D. # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Franklin Steineur Jr.		4. DATE OF DEATH Jan. 13, 19 61		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Gottysburg, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Steineur		14. MOTHER'S MAIDEN NAME Carrie Tate	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 166-12-6375		17. INFORMANT Mrs. Emily M. Steineur Westminster R.D. 1, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH yr		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James J. Marshall		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/13/61	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/61		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	
22d. LOCATION (City, town, or country) Gottysburg, Adams Co., Pa.		22e. REC'D BY REGISTRAR Arthur S. Kenna		22f. REGISTRAR'S SIGNATURE Arthur S. Kenna	
23. FUNERAL DIRECTOR J. Milton Bender		ADDRESS Gottysburg, Pa.		DATE JAN 16 '61	



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

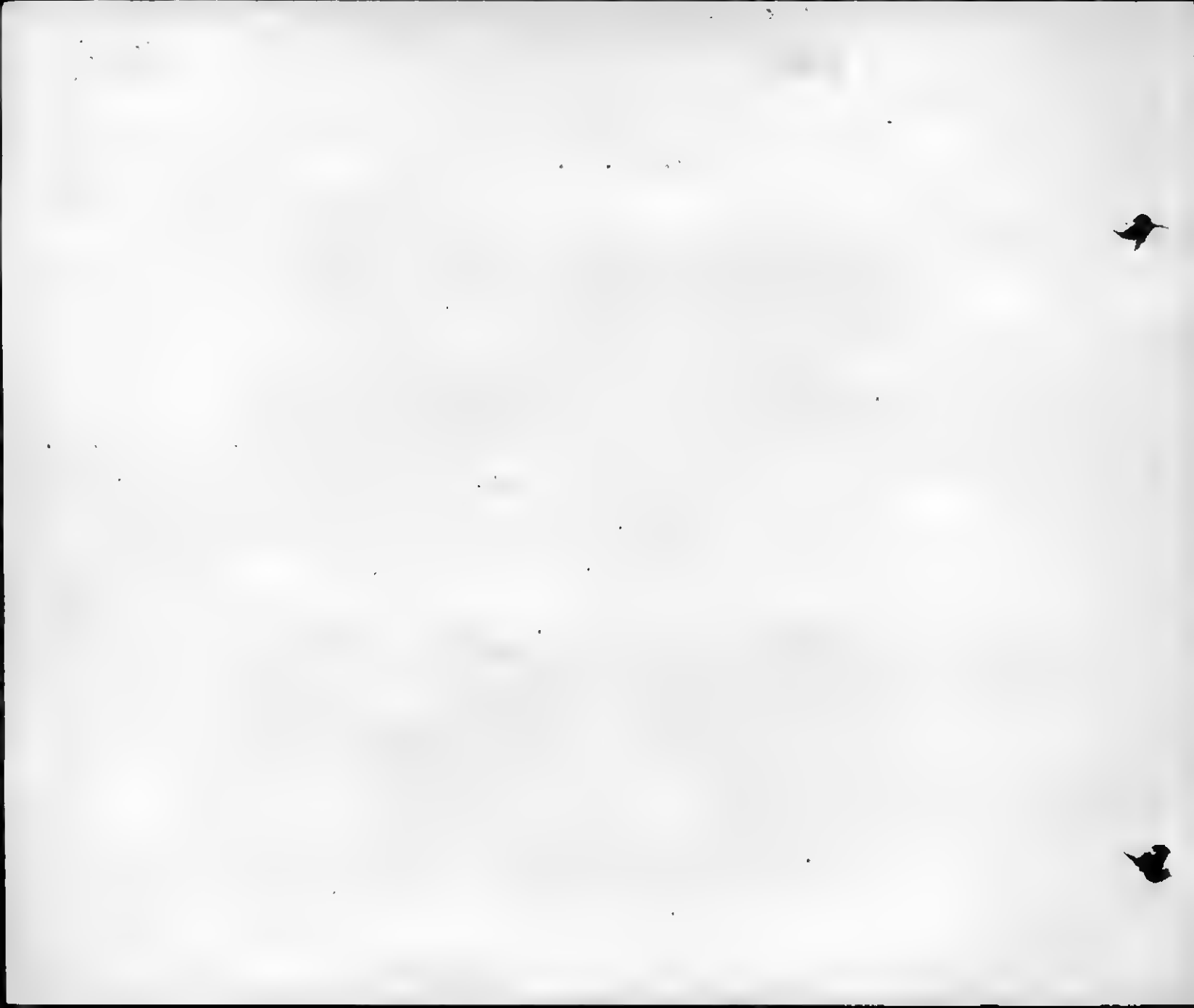
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474

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00472

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville				c. LENGTH OF STAY IN 1b 4y. 12m. 4d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Loretta Middle May Last Stroner				4. DATE OF DEATH Month 1 Day 19 Year 1961			
5 SEX female		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 8/21/05	
9 AGE (in years last birthday) 55 yrs		IF UNDER 1 YEAR Months 5 Days 19 Hours 19 Min 19		IF UNDER 24 HRS Months 5 Days 19 Hours 19 Min 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William M. McGreevy				14. MOTHER'S MAIDEN NAME Ruppell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16 SOCIAL SECURITY NO. unk -		17 INFORMANT Address Springfield Hospital records, Sykesville, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Myocarditis DUE TO (b) Subaortic Stenosis DUE TO (c) Upper Respiratory Tract Infection CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type. INTERVAL BETWEEN ONSET AND DEATH days years day							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 27, 1961 to 1/19/1961 , that (if (we) last saw the deceased alive on 1/19/1961 , and that death occurred at 11:00 PM from the causes and on the date stated above							
22a SIGNATURE Rita S. Glahn				22b DATE SIGNED 1/19/61			
22c PHYSICIAN'S NAME (Type) Rita S. Glahn				22d ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-27-61		23c. NAME OF CEMETERY OR CREMATORY New-Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Arthur S. Haight				25a. REC'D BY REGISTRAR DATE JAN 30 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Haight	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

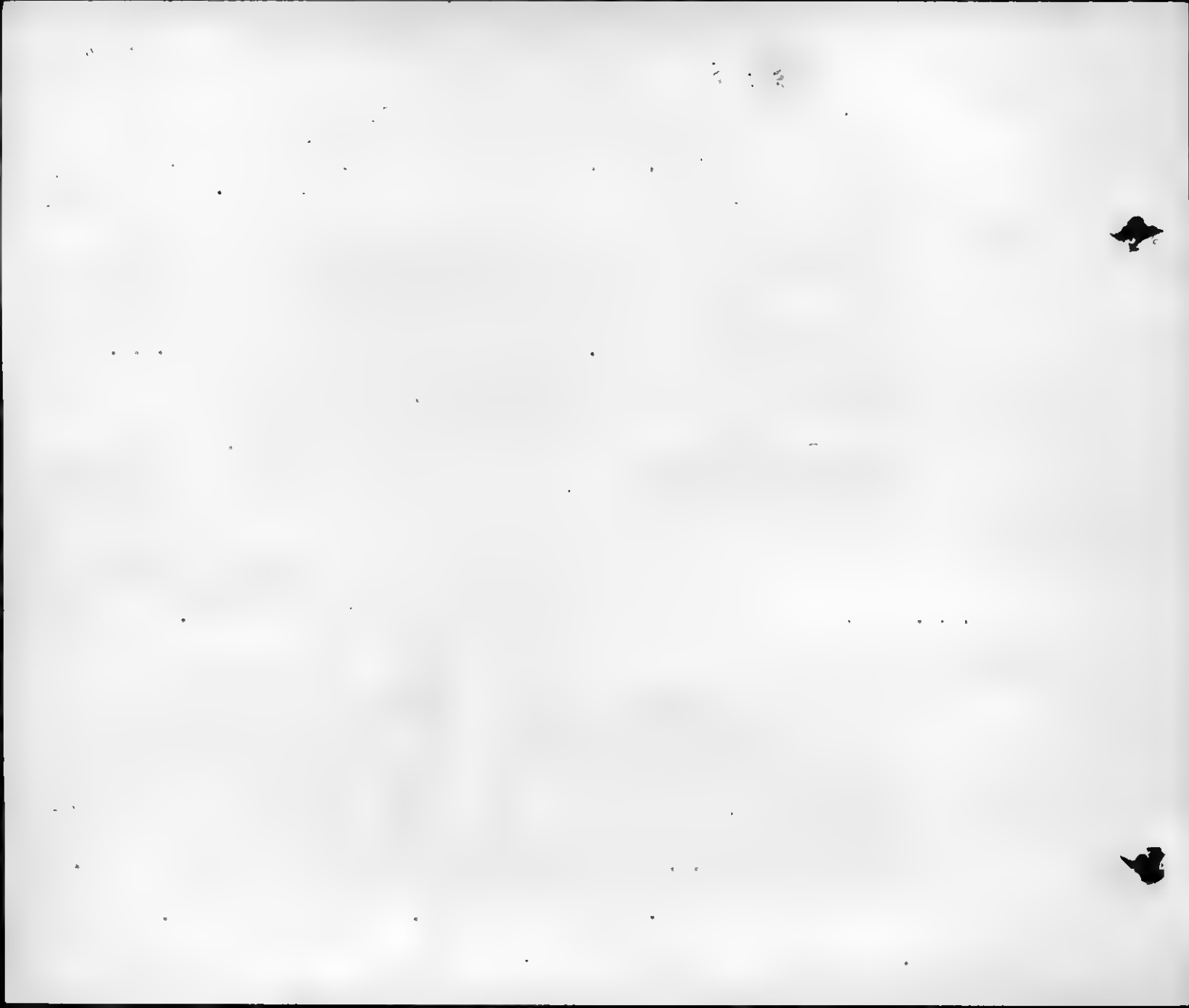
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CERTIFICATE OF DEATH

60473

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>2yrs. 6mos. 28days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Had been/ at Henryton Hospital & lived</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>Other address unknown.</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Richard</u> Last <u>Swankhaus</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 17, 1899</u>	
9. AGE (In years lost birthday) <u>61</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Senior clerk</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Michael Swankhaus</u>	
14. MOTHER'S MAIDEN NAME <u>Lena Hite Swankhaus</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>		17. INFORMANT <u>Springfield Hospital Records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, left lung</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1958</u> to <u>January 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>January 8 1961</u> and that death occurred at <u>7PM</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Agustin del Campo</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>				22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-12-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				ADDRESS <u> </u>		25a. REC'D BY REGISTRAR <u>DATE JAN 11 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>				25c. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

476

00476

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REESE</u>		c. LENGTH OF STAY IN 1b <u>40 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reese</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster RD #4</u>				d. STREET ADDRESS <u>Westminster RD #4</u>			
3. NAME OF DECEASED (Type or print) <u>HOWARD RANSY TAYLOR</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1882</u>		9. AGE (in years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer, County Roads Dept.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eliyah Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Susan Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. H. R. Taylor, Reese, Md.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, & Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1960</u> to <u>Jan 30, 1961</u> , that (I) <u> </u> last saw the deceased alive on <u>Jan 29, 1961</u> , and that death occurred at <u>9:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. L. Speicher</u>				22b. DATE <u>1/30/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Westminster Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lexington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

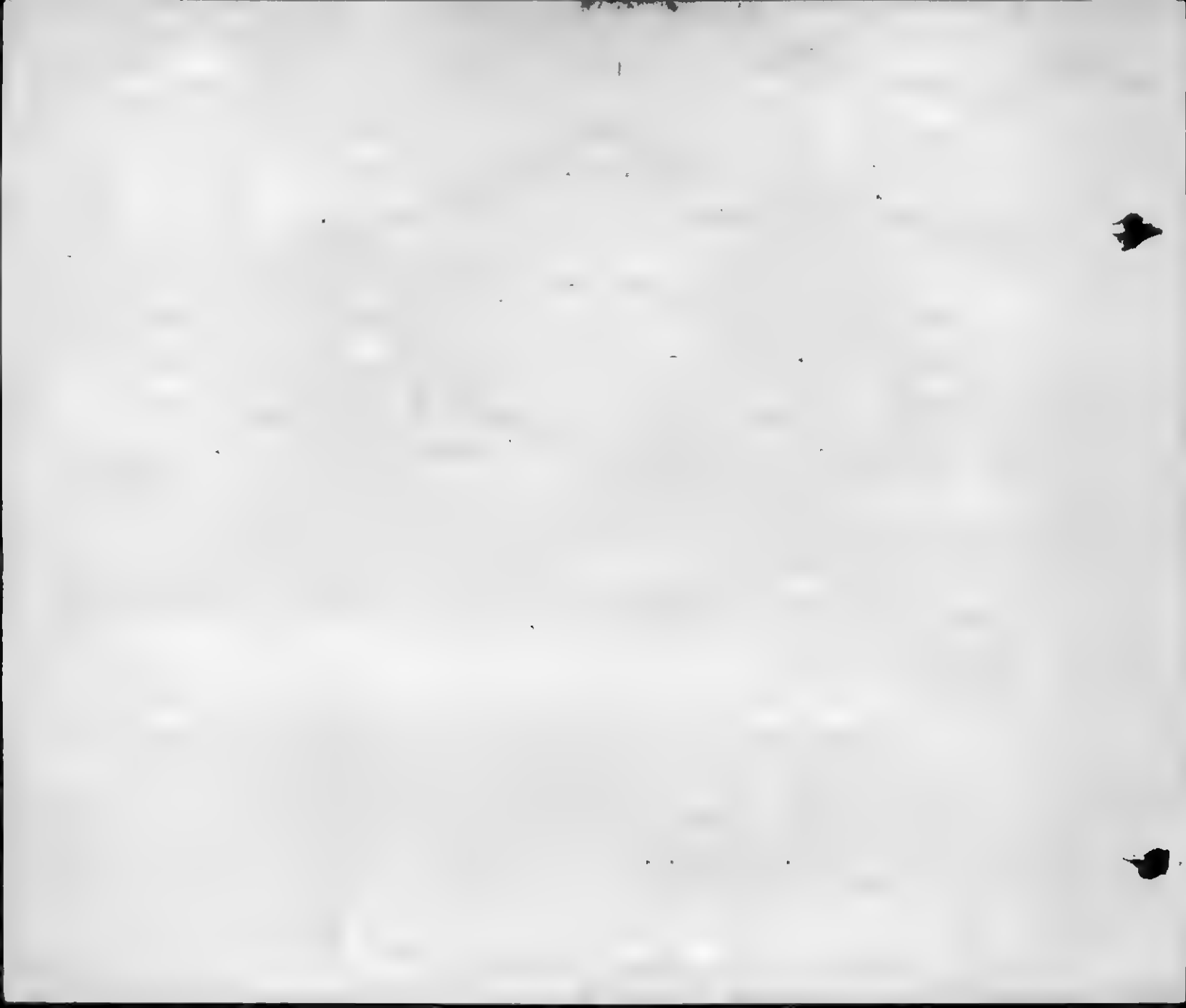
VS. A15ME
5M 7/11

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
47 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00475

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN IL <u>35 yrs. 4 mos. 15 days</u> <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>903 Bevans St.</u>	
3. NAME OF DECEASED (Type or print) <u>Harry Vanlusen</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1900</u>	
9. AGE (In years) If UNDER 1 YEAR last birthday) Months Days Hours Min. <u>60 yrs.</u>		10. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown - none.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Alien</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental deficiency, idiopathic, severe.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>min</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-2-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>Luther H. Haight</u>		24a. REC'D BY REGISTRAR <u>Stykenell; Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		DATE <u>JAN 9 '61</u>	



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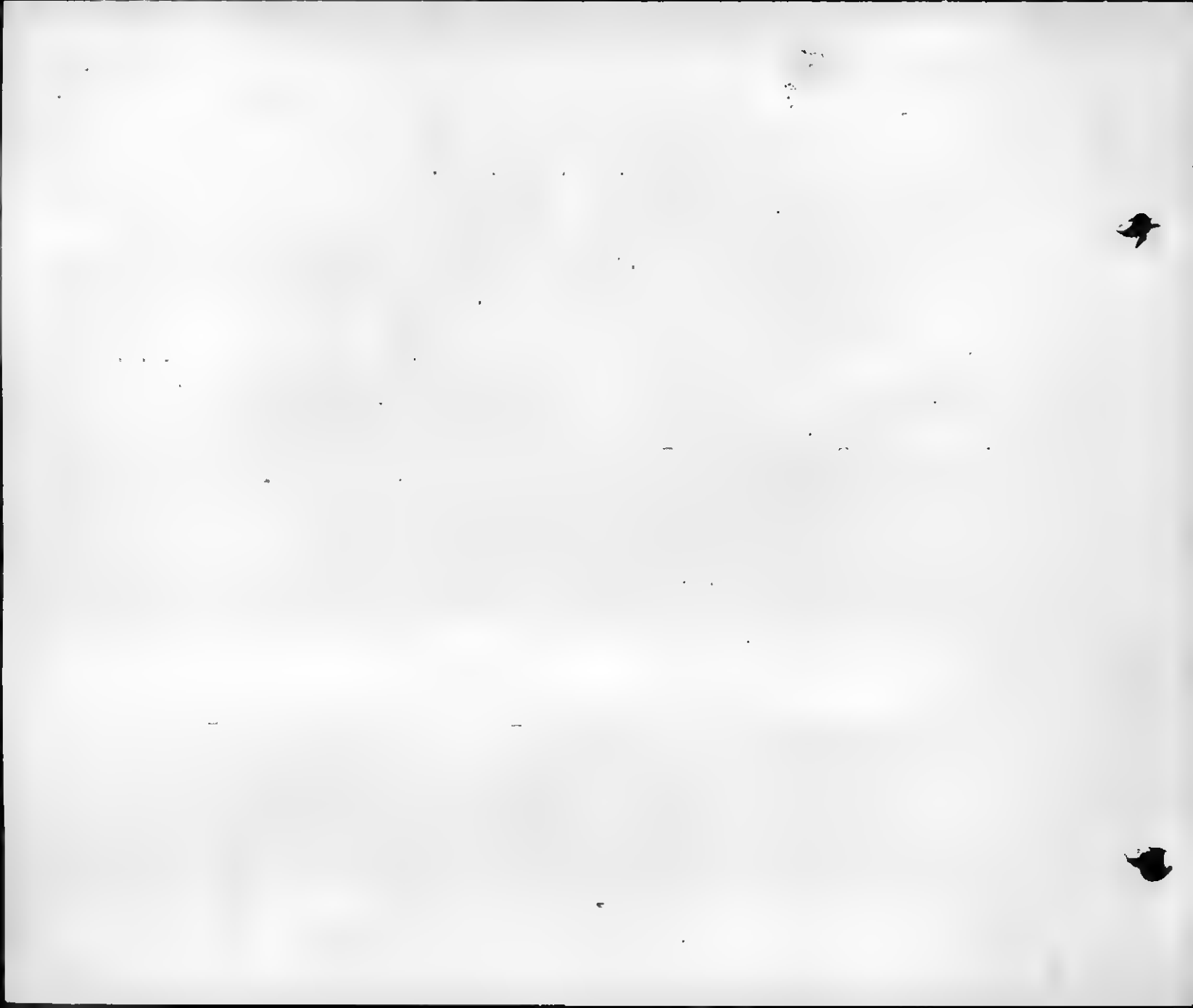
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

60476

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 yrs. 7 mos. 20 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First William Middle ANDREW Last Vosburgh				4. DATE OF DEATH Month January Day 24 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-1889		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 71 Days 24 Hours 19 Min 61	IF UNDER 24 HRS Hours 19 Min 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW W. Edward Vosburgh				14. MOTHER'S MAIDEN NAME Frances Hitchcock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes World War I		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Coronary Occlusion DUE TO (c) Arteriosclerotic Cardiovascular Disease							INTERVAL BETWEEN ONSET AND DEATH hours hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -					
20c. TIME OF INJURY Month, Day, Year Hour a. m. - p. m. - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that (I) (this hospital) attended the deceased from 6-4- 1958 , to 1-24- 1961 , that (I) (we) last saw the deceased alive on 1-24- 1961 , and that death occurred at 7 A.M., from the causes and on the date stated above.							
22a. SIGNATURE Agustín del Campo M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-24-61	
22c. PHYSICIAN'S NAME (Type) Agustín del Campo				22d. ADDRESS Springfield State Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/28/61		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery, Westminster, Md.		23d. LOCATION (City, town, or county) (State) Westminster, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr.				25a. REC'D BY REGISTRAR JAN 27 '61		25b. REGISTRAR'S SIGNATURE Charles S. Finner	

TO REGISTER OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

479

00477

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 18yrs15days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY City 311	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS 6206 Alameda		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Wilhelm Last Wagner		4. DATE OF DEATH Month 1 Day 15 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 68-1-58	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy dipper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Abraham Wilhelm		14. MOTHER'S MAIDEN NAME Mary Piffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 220-14-6260		17. INFORMANT Hospital records Sykesville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 1420.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia paranoid type. Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH years years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-14-1961 to 1-15-1961 that (I) (we) last saw the deceased alive on 1-15-1961 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.					
22a. SIGNATURE J. Raymond Gladue MD		22b. ADDRESS Springfield State Hospital, Sykesville, Md.		22c. DATE SIGNED 1-15-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19/61		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.	
23d. LOCATION (City, town, or county) (State) Balto, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons		25a. REC'D BY REG STRAR 2024 Orleans St. DATE JAN 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kears					



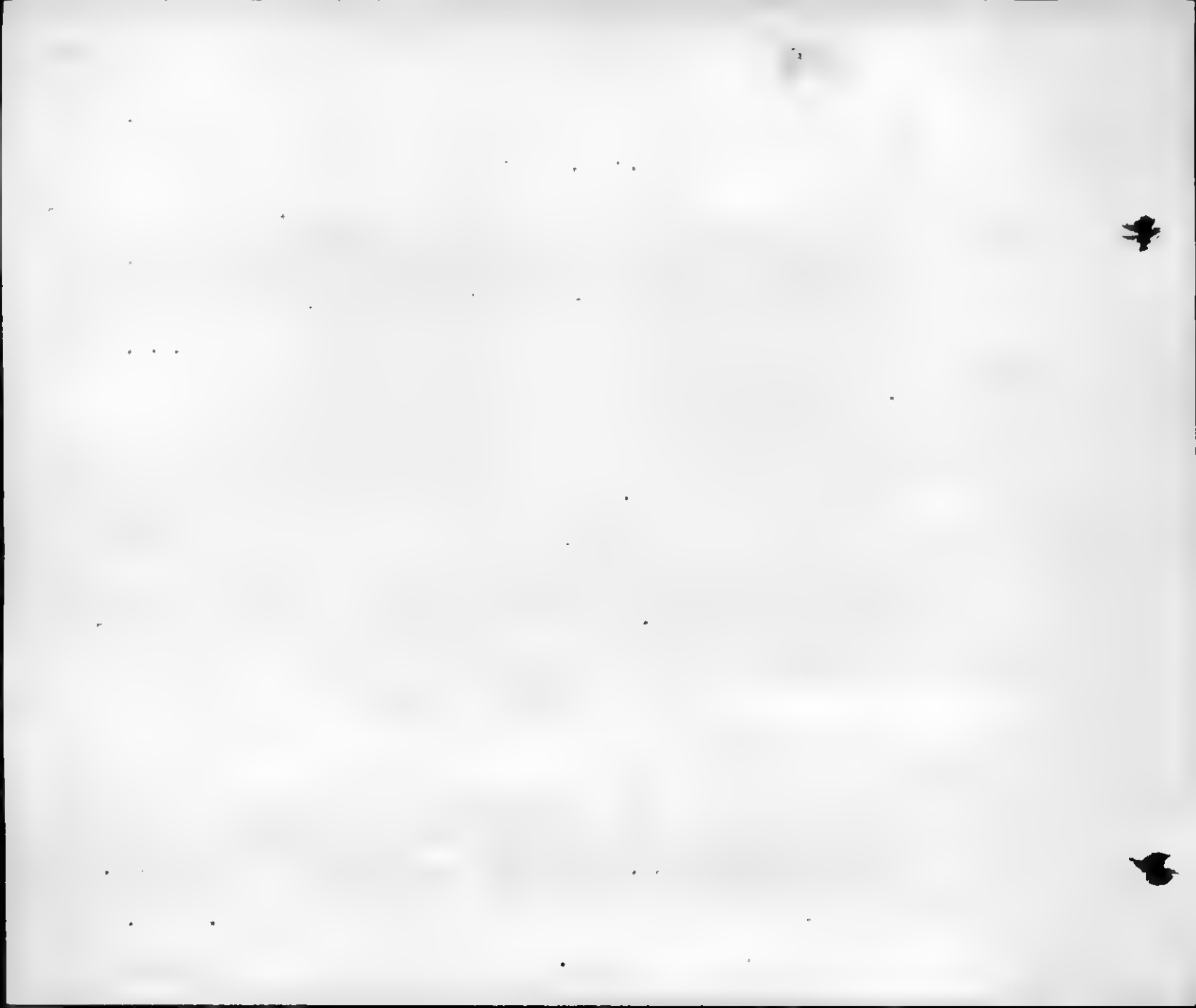
may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

480

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60478

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto, City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 15yrs. 4mos. 23days Baltimore 26	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3619 Everett St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle F. Last Waldman		4. DATE OF DEATH Month January Day 22, Year 1961	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28, 1911
9. AGE (In years last birthday) 49 yrs		IF UNDER 1 YEAR: Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Junious T. Clark		14. MOTHER'S MAIDEN NAME Margaret McGarrity	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 410X IMMEDIATE CAUSE (a) Mitral stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 to January 22, 1961 , that (I) (we) last saw the deceased alive on January 22, 1961 , and that death occurred at 2:15 PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 1/23/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 25, 1961	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION (City, town, or county) (State) Ritchie Hwy, A. A. Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE FLYNN & FLEMING, INC. 1422 Light St.		25a. REC'D BY REGISTRAR DATE JAN 24 '61	
		25b. REGISTRAR'S SIGNATURE William L. Hume	



FOR STATE
HEALTH DEPT.

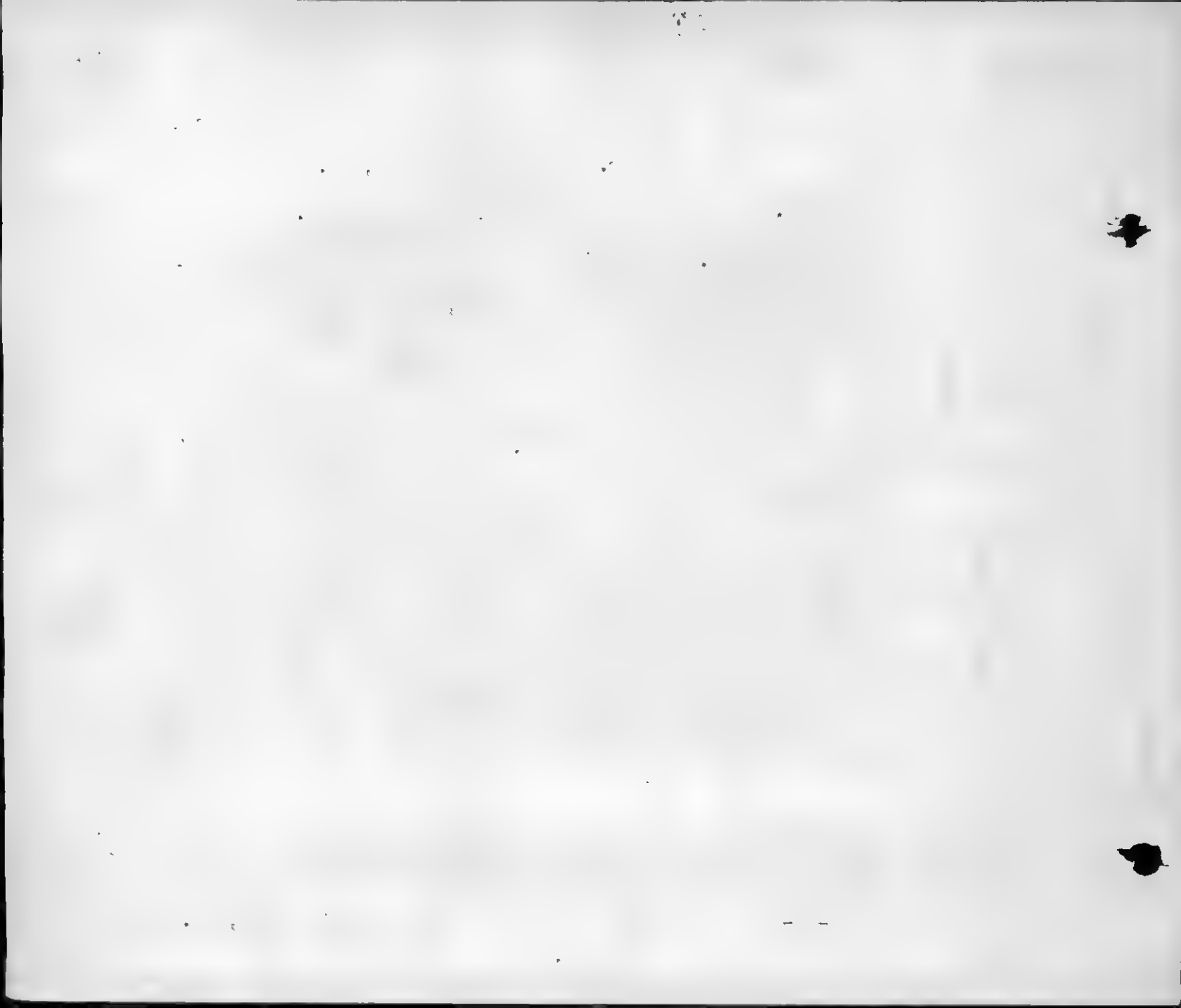
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

60479

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Westminister c. LENGTH OF STAY IN 1b 5 yr. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 109 East Main St.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Westminister, Md. d. STREET ADDRESS 109 East Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen E. Watkins		4. DATE OF DEATH Month January Day 16 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 10 Days 12	
11. IF UNDER 24 HRS Hours 10 Min 12		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Basil Buxton		14. MOTHER'S MAIDEN NAME Charlotte Brandenburg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Lucy Swartzbaugh		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b) Coronary Arteriosclerosis (c), stating the underlying cause last. Hypertension		INTERVAL BETWEEN ONSET AND DEATH Short Time 10-12 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature] EXAMINER'S NAME (Type) acting		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/16/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-61	
22c. NAME OF CEMETERY OR CREMATORY Montgomery		22d. LOCATION (City, town, or county) (State) Claggettville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		24a. REC'D BY REGISTRAR JAN 19 1961	
24b. REGISTRAR'S SIGNATURE Laytonsville, Md.		24c. REGISTRAR'S SIGNATURE Arthur L. Kline	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

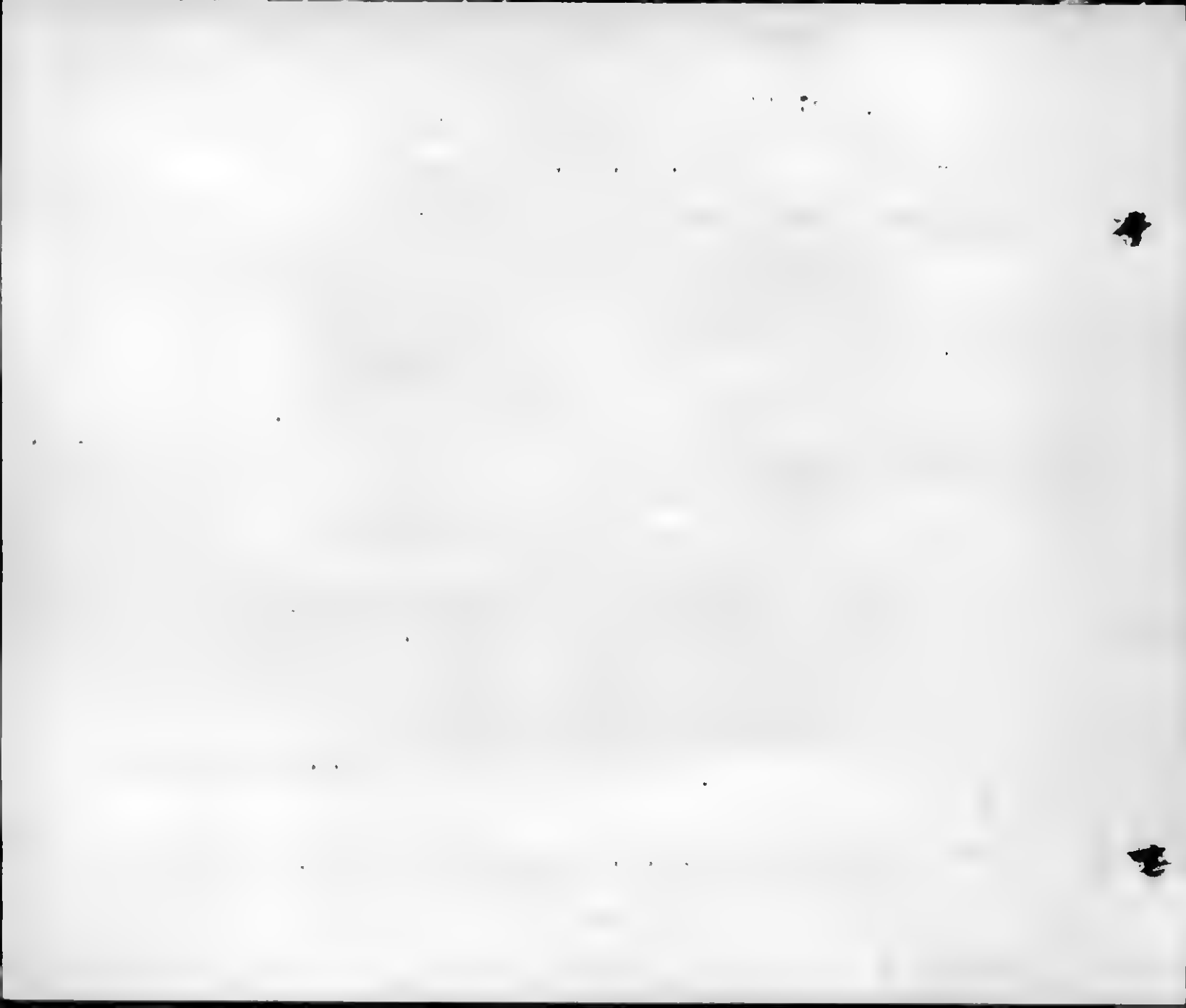
VR A15 (4)
ISM 9/59

482

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00480

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 6y. 10m. 27d.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3023 Abell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Ellen Last Weaver	4. DATE OF DEATH Month 1 Day 17 Year 1961				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/7/69	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months 2 Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Rolandus Gross		14. MOTHER'S MAIDEN NAME Seifert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Springfield Hosp. records Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Coronary arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH Days Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis with psychotic reaction.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/20/1954 to 1/17/1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/17/1961 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Konstantin Weber M.D.		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.	
22d. ADDRESS Springfield State Hospital		22e. REGISTRAR'S SIGNATURE Arthur L. Knaus			
22f. DATE JAN 20 '61		22g. REGISTRAR'S SIGNATURE			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 20, 1961		23c. NAME OF CEMETERY OR CREMATORY Greenmount	
23d. LOCATION (City, town, or county) York, York Co. Pa.					



CERTIFICATE OF DEATH

Reg. Dist. No.

00481

483

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WESTMINSTER		c. LENGTH OF STAY IN 1b 4-5 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 LOCUST AVE		e. STREET ADDRESS 119 LOCUST AVE	
3. NAME OF DECEASED (Type or print) First Middle Last LUTHER SILL WENTZ		4. DATE OF DEATH Month Day Year JANUARY 20 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH See 10-1881
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY NURSERY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME I Valentine Wentz		14. MOTHER'S MAIDEN NAME Susan Tracy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-09-1944A	
17. INFORMANT MR. FLETCHER MCALASTER		Address WESTMINSTER MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DIS. DUE TO (c) 10 YEARS		INTERVAL BETWEEN ONSET AND DEATH 7 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY 1961 to JANUARY 1961 , that I last saw the deceased alive on JANUARY 20, 1961 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel I Welliver M.D.		ADDRESS (Street, city or town, state) 19 RIDGE ROAD, 1-20-61	
PHYSICIAN'S NAME (Type) DANIEL I WELLIVER M.D. WESTMINSTER, MD.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Jan. 24/61	Manchester Cem	Carroll Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Edw. H. Hopton		ADDRESS Hamstead Md	
24a. REC'D BY REGISTRAR DATE JAN 24 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

400

1931

DATE OF DEATH		JANUARY 23 1931	
PLACE OF DEATH		ST. LOUIS, MO.	
DECEASED'S NAME		LUTHER E. WHITE	
AGE		42 YEARS	
SEX		MALE	
RACE		WHITE	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. [illegible]	
SIGNATURE OF MINISTER		[illegible]	
SIGNATURE OF CORONER		[illegible]	
SIGNATURE OF JURY		[illegible]	
SIGNATURE OF DEATH REGISTRAR		[illegible]	
SIGNATURE OF COUNTY CLERK		[illegible]	
SIGNATURE OF CITY CLERK		[illegible]	
SIGNATURE OF STATE CLERK		[illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

484 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

60482

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>17yrs. 8mos. 19days</u> <u>Baltimore 17</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1700 Eutaw Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>May</u> Last <u>Wolf</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Edward Wolf</u>			
14. MOTHER'S MAIDEN NAME <u>Mary List</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental deficiency without psychosis.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell out of bed, causing old scar on back of head to re-open.</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> o. m. <u>AM</u> P. m. <u> </u> <u>1/24/</u> <u>1961</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20f. (City or town) <u>Sykesville</u>				(County) <u>Carroll</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1/25/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1/27/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORAINE CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>BALTIMORE</u>				(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. F. EVANS & SON 118 W. Mt. Royal Ave</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

11. Signature of Physician: _____

12. Signature of Family: _____

13. Signature of Other: _____

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